

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12934

## 11706 CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>3V01.4</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>2509 Dulaney Street</b>			
3. NAME OF DECEASED (Type or print) First <b>Theresa</b> Middle <b>Auberger</b> Last <b>Auberger</b>				4. DATE OF DEATH Month <b>11</b> Day <b>30</b> Year <b>1957</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-27-92</b>	
9. AGE (In years last birthday) <b>65</b> yrs.		IF UNDER 1 YEAR Months <b>6</b> Days <b>5</b> Hours <b>15</b> Min.		11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Germany</b>	
13. FATHER'S NAME <b>John Younger</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>unkn</b>		17. INFORMANT <b>S.S. Hosp. Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary embolism</b> <b>465x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Paranoid condition</b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>7-1-</b> , 19 <b>50</b> , to <b>11-30-</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>11-30-</b> , 19 <b>57</b> , and that death occurred at <b>8:15 P</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Walther H. Sonnenfeldt</b> M.D.				ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>			
DATE SIGNED <b>12-1-57</b>							
PHYSICIAN'S NAME (Type) <b>Walther H. Sonnenfeldt M.D.</b>				<b>Sykesville, Maryland.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Cremation</b>		<b>Dec 4/57</b>		<b>New Calhoun</b>		<b>Marble Hill</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>F. J. Wipbert</b>				ADDRESS <b>1300 E. Haw Place</b>		24a. REC'D BY REGISTRAR <b>DATE</b>	
24b. REGISTRAR'S SIGNATURE <b>Harry Steer</b>							

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11713  
74

## 11707 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>5 yrs. 11 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>	
3. NAME OF DECEASED (Type or print) First <b>Virginia</b> Middle <b>Estelle</b> Last <b>Tefft BALDWIN</b>		4. DATE OF DEATH Month <b>November</b> Day <b>11</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 28, 1873</b>
9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Kentucky</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>Julius L. Tefft</b>		14. MOTHER'S MAIDEN NAME <b>Frances L. Tefft</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with dist. of growth, metabolism or nutrition; senile brain disease with psychotic reaction.</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b> <b>Years</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month Day Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October 30, 1952</b> , to <b>November 11, 1957</b> , that I last saw the deceased alive on <b>November 11, 1957</b> , and that death occurred at <b>9:34 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>11/12/57</b> ACTUAL SIGNATURE <b>Walther H. Sonnenfeldt</b> M.D. <b>Walther H. Sonnenfeldt, M.D.</b> <b>Sykesville, Maryland</b> PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/16/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Parklawn</b>		22d. LOCATION (City, town, or county) (State) <b>Rockville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert A. Pumphrey-Bethesda, Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 18 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>C. Harry Hays</b>			

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11708 CERTIFICATE OF DEATH

11714

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>---</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Sykesville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> 3 Vol. 4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>923 W. Barre St., #30</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Peter</b> Middle <b>Joseph</b> Last <b>BAUERNSCHUB</b>				4. DATE OF DEATH Month <b>November</b> Day <b>23</b> Year <b>19 57</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 20, 1901</b>		9. AGE (In years last birthday) yrs. <b>56</b>	IF UNDER 1 YEAR Months <b>---</b> Days <b>---</b>	IF UNDER 24 HRS. Hours <b>---</b> Min. <b>---</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bartender</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore City, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>
13. FATHER'S NAME <b>Joseph Bauernschub</b>				14. MOTHER'S MAIDEN NAME <b>Myra Dorne</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT <b>Records of Springfield State Hospital</b>		Address <b>Sykesville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute bronchopneumonia - bilateral</b> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>---</b> DUE TO (c) <b>---</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3-4 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Psychosis with syphilitic meningo-encephalitis.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <b>---</b>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>---</b>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>---</b> p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>---</b>	
				20f. (City or town) <b>---</b>		(County) <b>---</b> (State) <b>---</b>	
21. I certify that I attended the deceased from <b>September 1, 19 47</b> to <b>Nov. 22, 19 57</b> , that I last saw the deceased alive on <b>November 22, 19 57</b> , and that death occurred at <b>5:55A</b> M, from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>				DATE SIGNED <b>11/25/57</b>			
ACTUAL SIGNATURE <b>Martin Gross</b>				M.D. <b>Springfield State Hospital</b>			
PHYSICIAN'S NAME (Type) <b>Martin Gross, M. D.</b>				<b>Sykesville, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/27/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK</b>		22d. LOCATION (City, town, or county) (State) <b>Fredrick Rd Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. W. Kachawich</b>				24a. REC'D BY REGISTRAR <b>637</b>		24b. REGISTRAR'S SIGNATURE <b>C. Harry Meyer</b>	
				DATE <b>NOV 29 1957</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11715

Reg. Dist. No.

11709

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster x1</u>	d. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route 31</u>		d. STREET ADDRESS <u>Route 31</u>	
3. NAME OF DECEASED (Type or print) First <u>CALVIN</u> Middle <u>LUTHER</u> Last <u>BORTNER</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>6</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/22/98</u>
9. AGE (In years last birthday) <u>59</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 MRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Hand</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	11. BIRTHPLACE (State or foreign country) <u>Hanover, Pa. R. D.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Isaac Bortner</u>		14. MOTHER'S MAIDEN NAME <u>Lucinda Fuhrman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO. <u>183-09-1467</u>	17. INFORMANT <u>Mrs. Mary Kelly</u> Address <u>Mrs. Mary Kelly, R. D. 1, Hampstead, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CRUSHING INJURY TO SPINE AND CHEST</u> <u>812X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>  </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Struck by automobile as he crossed across road</u>		
20c. TIME OF INJURY Month, Day, Year <u>5</u> Hour <u>  </u> <u>  </u> p.m. <u>11/6</u> <u>1957</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 31</u>	20f. (City or town) (County) (State) <u>Westminster</u> <u>Carroll</u> <u>Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>James T. Marsh</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES T. MARSH</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/9/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Johns Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Littlestown, Adams Co., Pa.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard A. Little</u>		24a. REC'D BY REGISTRAR DATE <u>11-9-57</u>	24b. REGISTRAR'S SIGNATURE <u>Harriet Muller</u>

DATE SIGNED

11/6/57

from the ground and

NOV 13 1957

RECEIVED

With A. and S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11716

11710

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>3 yrs.23 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>-</b>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Arthur</b> Middle <b>Washington</b> Last <b>BROWN, Sr.</b>				4. DATE OF DEATH Month <b>November</b> Day <b>8,</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 22, 1883</b>	
9. AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months <b>74</b> Days <b>74</b> Hours <b>74</b> Min.		IF UNDER 24 HRS. Months <b>74</b> Days <b>74</b> Hours <b>74</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Agriculture</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>William A. Brown</b>				14. MOTHER'S MAIDEN NAME <b>Marion Lownsen</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>12-11-57</b>		17. INFORMANT <b>Springfield Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gangrene, right foot</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Obliteration of arterial circulation</b> DUE TO (c) <b>Generalized arteriosclerosis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>Days</b> <b>Days</b> <b>Years.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with dist. of metabolism, growth or nutrition, with senile brain disease with psychotic reaction, -Arteriosclerotic heart disease.</b>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Springfield</b>				20g. (County) <b>Montgomery</b>		20h. (State) <b>MD.</b>	
21. I certify that I attended the deceased from <b>October 15, 1954</b> , to <b>November 8, 1957</b> , that I last saw the deceased alive on <b>November 8, 1957</b> , and that death occurred at <b>11:35 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Walther H. Sonnenfeldt</b>				ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>			
DATE SIGNED <b>11/8/57</b>							
PHYSICIAN'S NAME (Type) <b>Walther H. Sonnenfeldt, M.D.</b>				<b>Sykesville, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-11-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt Carmel</b>		22d. LOCATION (City, town, or county) (State) <b>Montgomery Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Roy Barber</b>				ADDRESS <b>Raytonville, Md.</b>		24a. REC'D BY REGISTRAR <b>C. Harry Allen</b>	
24b. REGISTRAR'S SIGNATURE <b>C. Harry Allen</b>				DATE <b>11-8-57</b>			



# CERTIFICATE OF DEATH

6-1-10-11-12

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
MARRIAGE		EDUCATION		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
DATE OF DEATH		PLACE OF DEATH		TIME OF DEATH		TEMPERATURE		PULSE	
RESIDENCE		CITY		STATE		COUNTRY		HOSPITAL	
DATE OF INTERMENT		PLACE OF INTERMENT		TIME OF INTERMENT		TEMPERATURE		PULSE	
NAME OF FUNERAL HOME		CITY		STATE		COUNTRY		HOSPITAL	
DATE OF DEATH		PLACE OF DEATH		TIME OF DEATH		TEMPERATURE		PULSE	
RESIDENCE		CITY		STATE		COUNTRY		HOSPITAL	
DATE OF INTERMENT		PLACE OF INTERMENT		TIME OF INTERMENT		TEMPERATURE		PULSE	
NAME OF FUNERAL HOME		CITY		STATE		COUNTRY		HOSPITAL	

BUREAU V. S.

NOV 12 1957

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CITIZENSHIP BOARD



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11711

## CERTIFICATE OF DEATH

11717

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u> X2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>102 S Main St</u>		d. STREET ADDRESS <u>102 S Main St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Andrew Burgoon</u> First Middle Last		4. DATE OF DEATH <u>11 - 2</u> Month Day Year <u>1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/21/72</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carroll Co. md</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>J. W. F. Burgoon</u>		14. MOTHER'S MAIDEN NAME <u>Amanda Smeak</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>210-1627084</u>	
17. INFORMANT <u>Mary Burgoon</u> Address <u>102 S Main St</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u> <u>7 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct</u> , 19 <u>56</u> , to <u>Nov 2</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov 2</u> , 19 <u>57</u> , and that death occurred at <u>9 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W H Foward</u> M.D. <u>Manchester, Md</u> DATE SIGNED <u>11/2/57</u>			
PHYSICIAN'S NAME (Type) <u>W. H. Foward M.D.</u> <u>Manchester, Md</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/5/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Manchester Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Manchester, Carroll Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frederick Bucher Hanson Pa</u> ADDRESS <u>Pa</u>		24a. REC'D BY REGISTRAR <u>Caroline K. Hanson</u> DATE <u>11/5/57</u>	
		24b. REGISTRAR'S SIGNATURE <u>Caroline K. Hanson</u>	

100

## 11712 CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. LENGTH OF STAY IN 1b <u>7 yr. 7 mo 19 d</u>		
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 3401-4</u>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hosp.</u>		
d. STREET ADDRESS <u>304 S. Chester Street, Balto, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Burke</u> Last <u>Burke</u>		4. DATE OF DEATH Month <u>November</u> Day <u>30</u> Year <u>1957</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/26/93</u>	
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stacker-laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		
11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Joseph Burke</u>		14. MOTHER'S MAIDEN NAME <u>Constance Antkowiak</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>none</u>		16. SOCIAL SECURITY NO. <u>none</u>		
17. INFORMANT <u>Mrs John Burke</u>		Address <u>304 S. Chester Street Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1 Congestive heart failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic cardiovascular disease 8 years</u> DUE TO (c) <u>  </u>				INTERVAL BETWEEN ONSET AND DEATH <u>one day</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Psychosis with chronic alcoholism, deterioration</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> Month <u>  </u> Day <u>  </u> Year <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		20g. (County)		20h. (State)
21. I certify that I attended the deceased from <u>7-14-1950</u> to <u>11-30-1957</u> , that I last saw the deceased alive on <u>11-30-1957</u> , and that death occurred at <u>10:30 P.M.</u> , from the causes and on the date stated above.				
ACTUAL SIGNATURE <u>Walther H. Sonnenfeldt</u>		ADDRESS (Street, city or town, state) <u>Springfield Hall Hospital, Md.</u>		
DATE SIGNED <u>11-5-57</u>		PHYSICIAN'S NAME (Type) <u>Walther H. Sonnenfeldt</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>12-4-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Holy Rosary</u>
22d. LOCATION (City, town, or county) <u>Baltimore, Md.</u>		22e. (State) <u>Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Zaden</u>		ADDRESS <u>in Eastern Ave Balto</u>		24a. REC'D BY REGISTRAR <u>C. Harry Weber</u>
DATE <u>12-1-57</u>		24b. REGISTRAR'S SIGNATURE <u>C. Harry Weber</u>		

CERTIFICATE OF DEATH

DATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION		6. PLACE OF BIRTH		7. PLACE OF DEATH		8. DATE OF DEATH		9. TIME OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN		13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF DECEASED		16. SIGNATURE OF NEXT OF KIN		17. SIGNATURE OF BURIAL OFFICIAL		18. SIGNATURE OF FUNERAL HOME		19. SIGNATURE OF CHURCH		20. SIGNATURE OF OTHER			

BUREAU V. 2

DEC 3 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11719

11713

CERTIFICATE OF DEATH

Reg. Dist. No.

33

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Reisterstown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Grand View Nursing Home</b>		d. STREET ADDRESS <b>Butler Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Elizabeth</b> Last <b>Caples</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>11</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 29, 1874</b>
9. AGE (In years last birthday) <b>83</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Benjamin P. Ledley</b>		14. MOTHER'S MAIDEN NAME <b>Mary A. Wilson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>V.T. Caples Sr.</b>		Address <b>Reisterstown, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Arteriosclerosis</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>260x Diabetes</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>none</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <b>none 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <b>none</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>none</b>		20f. (City or town) (County) (State) <b>none</b>	
21. I certify that I attended the deceased from <b>Dec. 22, 1937</b> , to <b>Nov. 11, 1957</b> , that I last saw the deceased alive on <b>Nov. 11, 1957</b> , and that death occurred at <b>9:45 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>6 Hanover Rd.</b> DATE SIGNED <b>11-13-57</b>			
ACTUAL SIGNATURE <b>D. D. Caples</b>		M.D. <b>6 Hanover Rd.</b>	
PHYSICIAN'S NAME (Type) <b>D. D. Caples, M. D.</b>		Reisterstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Nov. 14, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Dover Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore County, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.F. Eline &amp; Sons, Reisterstown, Md.</b>		ADDRESS <b>Reisterstown, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>11-13-57</b>		24b. REGISTRAR'S SIGNATURE <b>Henry B. Eline</b> <b>C.H. Green, E.T.</b>	



BUREAU A. S.

NOV 15 1957

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## 117:4 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Taneytown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Rural Taneytown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Marian</u> Middle <u>Shoemaker</u> Last <u>Conover</u>		4. DATE OF DEATH Month <u>November</u> Day <u>23</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 1, 1881</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Greer Shoemaker</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Hill</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <u>Mr. Merle Conover, Penns Grove, New Jersey</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.0 Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio-Sclerotic Heart Disease</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>moderate Hypertension</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>57</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1941</u> , to <u>Nov 23</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov 23</u> , 19 <u>57</u> , and that death occurred at <u>8 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. Ambler Thompson</u> M.D.		ADDRESS (Street, city or town, state) <u>49 Frederick St, Taneytown, Md</u>	
DATE SIGNED <u>Nov 27 1957</u>			
PHYSICIAN'S NAME (Type) <u>E. Ambler Thompson</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/27/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Piney Creek Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Rural Taneytown, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>C.O. Fuss</u> ADDRESS <u>C.O. Fuss &amp; Son, Taneytown, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 27 57</u>	
24b. REGISTRAR'S SIGNATURE <u>  </u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED BURKAU V. S.		2. SEX Male		3. AGE 45	
4. DATE OF DEATH NOV 27 1957		5. TIME OF DEATH 10:00 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Myocardial Infarction		8. MANNER OF DEATH Natural		9. PLACE OF BIRTH Baltimore, Md.	
10. OCCUPATION Salesman		11. EDUCATION High School		12. RELIGION Roman Catholic	
13. MARITAL STATUS Married		14. NUMBER OF CHILDREN 3		15. PREVIOUS ILLNESS Hypertension	
16. SIGNATURE OF DECEASED (None)		17. SIGNATURE OF WITNESS (None)		18. SIGNATURE OF PHYSICIAN (None)	
19. SIGNATURE OF REGISTRAR (None)		20. SIGNATURE OF CLERK (None)		21. SIGNATURE OF JUDGE (None)	

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NOV 27 1957  
BURKAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4, Film G-222 11/7/57

CERTIFICATE OF DEATH

Reg. Dist. No.

11721

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>2 y 7 m 25 d</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>328 W. Lorraine Ave</b>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Raymond</b> Last <b>Cross</b>		4. DATE OF DEATH Month <b>11</b> Day <b>2</b> Year <b>1957</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-14-68</b>
9. AGE (In years last birthday) <b>89</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unkn</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>unkn</b>		14. MOTHER'S MAIDEN NAME <b>unkn</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>unkn</b>		16. SOCIAL SECURITY NO. <b>unkn</b>	
17. INFORMANT <b>S.S.Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral Bronchopneumonia</b> <b>491X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Basal cell carcinoma of face</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with circul. disturb. with cerebr. arterioscl. with psych. react. Urethral stone</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3-8-</b> <b>1955</b> , to <b>11-2-</b> <b>1957</b> , that I last saw the deceased alive on <b>11-2-</b> <b>1957</b> , and that death occurred at <b>9:20 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Springfield State Hospital</b> <b>11-3-57</b>			
ACTUAL SIGNATURE <b>Edmund Lusthaus</b> M.D.		PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus M.D.</b> <b>Sykesville, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>11-6-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>ST. MARY'S</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE, MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Paul E. Charnow</b>		ADDRESS <b>3615 17-19 Chestnut Ave</b>	
24a. REC'D BY REGISTRAR DATE <b>11/6/57</b>		24b. REGISTRAR'S SIGNATURE <b>C. Harry Perry</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

117:6

## CERTIFICATE OF DEATH

117224

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> 1011.2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				d. STREET ADDRESS <u>unknown</u>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>W.</u> Last <u>DEMORY</u>				4. DATE OF DEATH Month <u>November</u> Day <u>11</u> Year <u>1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>unknown</u>	9. AGE (In years last birthday) <u>71 ?</u> yrs.	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>		IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>unknown</u>	
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Records of Springfield State Hospital</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerosis</u> DUE TO <u>450.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic brain syndrome associated with disturbance of metabolism, growth or nutrition, with senile brain disease, with psychotic reaction.</u>							INTERVAL BETWEEN ONSET AND DEATH <u>more than 18 months</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>—</u> p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State) <u>—</u>
21. I certify that I attended the deceased from <u>October 29, 1956</u> , to <u>Nov. 11</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>November 11</u> , 19 <u>57</u> , and that death occurred at <u>9:35 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Martin Gross</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>M.D. Springfield State Hospital 11/13/57</u>			
PHYSICIAN'S NAME (Type) <u>Martin Gross, M.D.</u>				<u>Sykesville, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>11.14.57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Anatomy Board</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frank H. Newell, Sykesville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>11/18/57</u>		24b. REGISTRAR'S SIGNATURE <u>C. Harry Steers</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

REG. DIST. NO.

<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. DATE OF BIRTH</p> <p>4. PLACE OF BIRTH</p> <p>5. OCCUPATION</p> <p>6. MARITAL STATUS</p> <p>7. COLOR</p> <p>8. RELIGION</p> <p>9. EDUCATION</p> <p>10. PREVIOUS ILLNESS</p> <p>11. CAUSE OF DEATH</p> <p>12. PLACE OF DEATH</p> <p>13. TIME OF DEATH</p> <p>14. SIGNATURE OF PHYSICIAN</p> <p>15. SIGNATURE OF REGISTRAR</p> <p>16. SIGNATURE OF WITNESSES</p> <p>17. SIGNATURE OF CORONER</p> <p>18. SIGNATURE OF JURY</p> <p>19. SIGNATURE OF JUDGE</p> <p>20. SIGNATURE OF CLERK</p> <p>21. SIGNATURE OF SHERIFF</p> <p>22. SIGNATURE OF DEPUTY SHERIFF</p> <p>23. SIGNATURE OF CONSTABLE</p> <p>24. SIGNATURE OF DEPUTY CONSTABLE</p> <p>25. SIGNATURE OF TOWNSHIP CLERK</p> <p>26. SIGNATURE OF COUNTY CLERK</p> <p>27. SIGNATURE OF STATE CLERK</p> <p>28. SIGNATURE OF FEDERAL CLERK</p> <p>29. SIGNATURE OF MARSHAL</p> <p>30. SIGNATURE OF DEPUTY MARSHAL</p> <p>31. SIGNATURE OF SHERIFF</p> <p>32. SIGNATURE OF DEPUTY SHERIFF</p> <p>33. SIGNATURE OF CONSTABLE</p> <p>34. SIGNATURE OF DEPUTY CONSTABLE</p> <p>35. SIGNATURE OF TOWNSHIP CLERK</p> <p>36. SIGNATURE OF COUNTY CLERK</p> <p>37. SIGNATURE OF STATE CLERK</p> <p>38. SIGNATURE OF FEDERAL CLERK</p> <p>39. SIGNATURE OF MARSHAL</p> <p>40. SIGNATURE OF DEPUTY MARSHAL</p>		<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. DATE OF BIRTH</p> <p>4. PLACE OF BIRTH</p> <p>5. OCCUPATION</p> <p>6. MARITAL STATUS</p> <p>7. COLOR</p> <p>8. RELIGION</p> <p>9. EDUCATION</p> <p>10. PREVIOUS ILLNESS</p> <p>11. CAUSE OF DEATH</p> <p>12. PLACE OF DEATH</p> <p>13. TIME OF DEATH</p> <p>14. SIGNATURE OF PHYSICIAN</p> <p>15. SIGNATURE OF REGISTRAR</p> <p>16. SIGNATURE OF WITNESSES</p> <p>17. SIGNATURE OF CORONER</p> <p>18. SIGNATURE OF JURY</p> <p>19. SIGNATURE OF JUDGE</p> <p>20. SIGNATURE OF CLERK</p> <p>21. SIGNATURE OF SHERIFF</p> <p>22. SIGNATURE OF DEPUTY SHERIFF</p> <p>23. SIGNATURE OF CONSTABLE</p> <p>24. SIGNATURE OF DEPUTY CONSTABLE</p> <p>25. SIGNATURE OF TOWNSHIP CLERK</p> <p>26. SIGNATURE OF COUNTY CLERK</p> <p>27. SIGNATURE OF STATE CLERK</p> <p>28. SIGNATURE OF FEDERAL CLERK</p> <p>29. SIGNATURE OF MARSHAL</p> <p>30. SIGNATURE OF DEPUTY MARSHAL</p>
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11717

CERTIFICATE OF DEATH

11723

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b> c. LENGTH OF STAY IN 1b <b>4 months 18 days</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City 311</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>41 So. Poppleton St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Mary Ann Douglas</b>				4. DATE OF DEATH Month <b>11</b> Day <b>17</b> Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9-13-94</b>	
9. AGE (In years lost birthday) <b>63</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>William Schwartz</b>				14. MOTHER'S MAIDEN NAME <b>Maggie Admas</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Mr James Douglas</b> Address <b>41 So. Poppleton St.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Encephalomalacia of the internal capsul, due to hemorrhage.</b> <b>025X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>General paresis</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic brain syndrom with psychotic reaction.</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5-29-57</b> , 19 <b>57</b> , to <b>11-17</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>11-16-57</b> , 19 <b>57</b> , and that death occurred at <b>6:50 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Julian Radzykewycz</b>				ADDRESS (Street, city or town, state) <b>Sykesville Md,</b> DATE SIGNED <b>11-17-57</b>			
PHYSICIAN'S NAME (Type) <b>Dr. Julian. Radzykewycz</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/20/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Balto. National Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>5501 Federal Ave</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Gowan</b> ADDRESS <b>2401 Hollins St.</b>				24a. REC'D BY REGISTRAR <b>NOV 19 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Harry Keys</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Figure 11.10

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11718 CERTIFICATE OF DEATH

11724

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>5yrs. 4mos. 21days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>3202 Guilford Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>Susan</b> Middle <b>Gertrude</b> Last <b>Marshall</b> DOVE		4. DATE OF DEATH Month <b>November</b> Day <b>3</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 12, 1878</b>
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Marshall</b>		14. MOTHER'S MAIDEN NAME <b>Caroline Harris</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage from right lenticulo-striate artery</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. associated with disturbance of metabolism, growth or nutrition with senile brain disease with psychotic reaction.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 12, 1952</b> , to <b>November 3, 1957</b> , that I last saw the deceased alive on <b>November 3, 1957</b> , and that death occurred at <b>12:30P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Walther H. Sonnenfeldt</b>		M.D. <b>Springfield State Hospital</b>	
PHYSICIAN'S NAME (Type) <b>Walther H. Sonnenfeldt, M.D.</b>		<b>Sykesville, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>11/5/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>WOODLAWN</b>		22d. LOCATION (City, town, or county) (State) <b>WOODLAWN, BALTO. CO. MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.E. Swell</b>		ADDRESS <b>4611 Park Heights</b>	
24a. REC'D BY REGISTRAR <b>NOV 6 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Harry Henry</b>	

CERTIFICATE OF DEATH

1. PLACE OF DEATH  
2. DATE OF DEATH  
3. TIME OF DEATH  
4. SEX  
5. AGE  
6. OCCUPATION  
7. CAUSE OF DEATH  
8. MANNER OF DEATH  
9. SIGNATURE OF PHYSICIAN  
10. SIGNATURE OF REGISTRAR  
11. SIGNATURE OF WITNESSES  
12. SIGNATURE OF DECEASED  
13. SIGNATURE OF NEXT OF KIN  
14. SIGNATURE OF CLERGYMAN  
15. SIGNATURE OF MINISTER  
16. SIGNATURE OF CHURCH  
17. SIGNATURE OF FUNERAL HOME  
18. SIGNATURE OF BURIAL PLACE  
19. SIGNATURE OF CEMETERY  
20. SIGNATURE OF INTERMENT

BUREAU V. E.

NOV 6 1957

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11719 CERTIFICATE OF DEATH

11725

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>SYKESVILLE</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE CITY-311</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SPRINGFIELD STATE HOSP.</b>				d. STREET ADDRESS <b>860 W. 33rd STREET</b>			
3. NAME OF DECEASED (Type or print) First <b>GERTRUDE</b> Middle <b>FAULSTICH</b> Last <b>NOV.</b>				4. DATE OF DEATH Month <b>NOV.</b> Day <b>9</b> Year <b>1957</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-26-79</b>	9. AGE (In years lost birthday) <b>78</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>- none</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>EMMETT BARNSLEY</b>			14. MOTHER'S MAIDEN NAME <b>FRANCES BALDWIN</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>RECORDS AT SPRINGFIELD S. H.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC HEART DISEASE</b> <b>420.0</b> DUE TO <b>ARTERIOSCLEROSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) INTERVAL BETWEEN ONSET AND DEATH <b>YEARS</b> <b>YEARS</b> <b>WEEKS</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CBS DISTURBANCE OF METABOLISM, GROWTH OR NUTRITION, GENILE BRAIN DISEASE, PSYCHOTIC REC.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <b>Nov. 5</b> , 19 <b>57</b> , to <b>Nov. 9</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>November 9</b> , 19 <b>57</b> , and that death occurred at <b>9 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Elizabeth M. Kuopp</b>		M.D. <b>Springfield State Hosp, Sykesville</b>		DATE SIGNED <b>11-10-57</b>			
PHYSICIAN'S NAME (Type) <b>Elizabeth M. Kuopp</b>		<b>Springfield State Hosp, Sykesville, Md</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Nov. 13, 1957</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>	22d. LOCATION (City, town, or county)	(State) <b>Baltimore Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc.</b>		ADDRESS <b>1217 St. Paul Street</b>		24a. REC'D BY REGISTRAR DATE <b>11-11-57</b>	24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death; Page 4 may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED <b>EMMETT BARRETT</b>		AGE <b>44</b>		SEX <b>M</b>		RACE <b>W</b>		EDUCATION <b>GRADUATE</b>	
MARRIAGE <b>1912</b>		MARRIAGE <b>1912</b>		MARRIAGE <b>1912</b>		MARRIAGE <b>1912</b>		MARRIAGE <b>1912</b>	
PLACE OF BIRTH <b>BALTIMORE CITY</b>		PLACE OF BIRTH <b>BALTIMORE CITY</b>		PLACE OF BIRTH <b>BALTIMORE CITY</b>		PLACE OF BIRTH <b>BALTIMORE CITY</b>		PLACE OF BIRTH <b>BALTIMORE CITY</b>	
RESIDENCE <b>2011 W 34th STREET</b>		RESIDENCE <b>2011 W 34th STREET</b>		RESIDENCE <b>2011 W 34th STREET</b>		RESIDENCE <b>2011 W 34th STREET</b>		RESIDENCE <b>2011 W 34th STREET</b>	
DATE OF DEATH <b>NOV 20 1957</b>		DATE OF DEATH <b>NOV 20 1957</b>		DATE OF DEATH <b>NOV 20 1957</b>		DATE OF DEATH <b>NOV 20 1957</b>		DATE OF DEATH <b>NOV 20 1957</b>	
CAUSE OF DEATH <b>HEART DISEASE</b>		CAUSE OF DEATH <b>HEART DISEASE</b>		CAUSE OF DEATH <b>HEART DISEASE</b>		CAUSE OF DEATH <b>HEART DISEASE</b>		CAUSE OF DEATH <b>HEART DISEASE</b>	
MANNER OF DEATH <b>NATURAL</b>		MANNER OF DEATH <b>NATURAL</b>		MANNER OF DEATH <b>NATURAL</b>		MANNER OF DEATH <b>NATURAL</b>		MANNER OF DEATH <b>NATURAL</b>	
SIGNATURE OF DECEASED <b>EMMETT BARRETT</b>		SIGNATURE OF DECEASED <b>EMMETT BARRETT</b>		SIGNATURE OF DECEASED <b>EMMETT BARRETT</b>		SIGNATURE OF DECEASED <b>EMMETT BARRETT</b>		SIGNATURE OF DECEASED <b>EMMETT BARRETT</b>	
SIGNATURE OF WITNESS <b>FRANCES BARRETT</b>		SIGNATURE OF WITNESS <b>FRANCES BARRETT</b>		SIGNATURE OF WITNESS <b>FRANCES BARRETT</b>		SIGNATURE OF WITNESS <b>FRANCES BARRETT</b>		SIGNATURE OF WITNESS <b>FRANCES BARRETT</b>	
SIGNATURE OF PHYSICIAN <b>DR. H. H. H. H.</b>		SIGNATURE OF PHYSICIAN <b>DR. H. H. H. H.</b>		SIGNATURE OF PHYSICIAN <b>DR. H. H. H. H.</b>		SIGNATURE OF PHYSICIAN <b>DR. H. H. H. H.</b>		SIGNATURE OF PHYSICIAN <b>DR. H. H. H. H.</b>	

BUREAU V. S.

NOV 12 1957

RECEIVED



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 2/57

11720

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11726

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>---</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u>	
c. LENGTH OF STAY IN 1b <u>since 8-2-55</u>		d. STREET ADDRESS <u>602 Cathedral St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>George Americus</u> <u>Finch</u>		4. DATE OF DEATH Month Day Year <u>Nov.</u> <u>28</u> <u>19 57</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-27-81</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Ymk</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Roland W. Finch</u>		14. MOTHER'S MAIDEN NAME <u>George Ella Rayme</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>Ymk</u>	
17. INFORMANT <u>Records of Springfield State Hospital</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Arteriosclerosis C.V. disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) <u>422.1</u> DUE TO causes lost. INTERVAL BETWEEN ONSET AND DEATH <u>years.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James J. Marsh</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JAMES T. MARSH</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <u>11/28/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-2-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Handwritten</u>		ADDRESS <u>Baltimore, Md.</u>	
24a. REC'D BY REGISTRAR <u>C. H. W. W.</u>		24b. REGISTRAR'S SIGNATURE <u>C. H. W. W.</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

Form with multiple sections for medical examination and death certification, including fields for name, age, sex, race, date of death, and cause of death. The form is oriented horizontally but contains vertical text on the right side.

RECEIVED  
DEC 2 1957  
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11721

## CERTIFICATE OF DEATH

11727

Reg. Dist. No.

70

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>				c. LENGTH OF STAY IN 1b <u>2 1/2 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Long View Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>CLARA</u> Middle <u>B.</u> Last <u>Fogle</u>				4. DATE OF DEATH Month <u>11</u> Day <u>28</u> Year <u>1957</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-14-1881</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Wesley F. Barnes</u>				14. MOTHER'S MAIDEN NAME <u>Columbia E. Streaker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT <u>Mrs. Paul Therit, Manchester, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Diabetes</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u> <u>5 yrs</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>April</u> , 19 <u>55</u> , to <u>Nov 28</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov 28</u> , 19 <u>57</u> , and that death occurred at <u>8:50 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>MANCHESTER, MD</u> DATE SIGNED <u>11/29/57</u> ACTUAL SIGNATURE <u>W. H. Foard</u> M.D. <u>MANCHESTER, MD</u> PHYSICIAN'S NAME (Type) <u>W. H. Foard M.D.</u> <u>MANCHESTER, MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12-2-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Messiah Lutheran</u>		22d. LOCATION (City, town, or county) (State) <u>Carroll Co., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. M. Waltz,</u>				ADDRESS <u>Winfield, Maryland</u>		24a. REC'D BY REGISTRAR <u>DEC 3 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Mrs. McNeary</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1995-1996

**BUREAU V. S.**

DEC 3 1957

RECEIVED

11722

## CERTIFICATE OF DEATH

Reg. Dist. No.

76

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - Westminster</u>		c. LENGTH OF STAY IN 1b <u>28 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>ELLA</u> First <u>MAY</u> Middle <u>TOSSOFF</u> Last		4. DATE OF DEATH <u>NOV</u> Month <u>27</u> Day <u>1957</u> Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/27/1878</u>
9. AGE (In years and birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William R. Williams</u>		14. MOTHER'S MAIDEN NAME <u>MILESANN TURFEL</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>n.a.</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>Mrs. Jack Brothers</u> Address <u>SAME</u>			
18. CAUSE OF DEATH [Enter only one cause on line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Decident</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension and Cardiovascular Disease</u> DUE TO (c) <u>years.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>10/13</u> , 19 <u>57</u> , to <u>11/27</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11/27</u> , 19 <u>57</u> , and that death occurred at <u>8:30 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. Allen Moulton</u>		ADDRESS (Street, city or town, state) <u>Westminster, Md.</u>	
PHYSICIAN'S NAME (Type) <u>G. ALLEN MOULTON, M.D.</u>		DATE SIGNED <u>11/28/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-30-1957</u>	22c. NAME OF CEMETERY OR CREMATORIUM <u>DEER PARK</u>
22d. LOCATION (City, town, or county) <u>Carroll Co.</u>		(State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. M. Walz</u>		ADDRESS <u>Winfield, Md.</u>	
24a. REC'D BY REGISTRAR <u>DEC 2 1957</u>		24b. REGISTRAR'S SIGNATURE <u>May Harris</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		OCCUPATION		EDUCATION		MARRIAGE		RELIGION		RACE		COLOR		ETHNIC ORIGIN		SPOUSE'S NAME		SPOUSE'S DATE OF BIRTH		SPOUSE'S PLACE OF BIRTH		SPOUSE'S OCCUPATION		SPOUSE'S EDUCATION		SPOUSE'S RELIGION		SPOUSE'S RACE		SPOUSE'S COLOR		SPOUSE'S ETHNIC ORIGIN	
JAMES H. HARRIS		M		45		1880		BALTIMORE, MD.		CLERK		HIGH SCHOOL		MARRIED		METHODIST		WHITE		WHITE		AMERICAN		JAMES H. HARRIS		1880		BALTIMORE, MD.		CLERK		HIGH SCHOOL		METHODIST		WHITE		WHITE		AMERICAN	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		DATE OF BURIAL		PLACE OF BURIAL		NAME OF FUNERAL HOME		NAME OF MINISTER		NAME OF CHURCH		NAME OF CEMETERY		NAME OF INTERVIEWER		NAME OF WITNESS		NAME OF SIGNER		NAME OF SIGNER		NAME OF SIGNER		NAME OF SIGNER		NAME OF SIGNER		NAME OF SIGNER		NAME OF SIGNER		NAME OF SIGNER	
1937		BALTIMORE, MD.		HEART DISEASE		NATURAL		10 DAYS		1937		BALTIMORE, MD.		HARRIS & SONS		JAMES H. HARRIS		METHODIST CHURCH		GREENWICH CEMETERY		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS		JAMES H. HARRIS	

RECEIVED  
DEC 2 1937  
BUREAU V. 3

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
11723 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11729

Reg. Dist. No. 82

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodbine</b>		c. LENGTH OF STAY IN 1b <b>Life</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodbine</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <b>/</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM</b> Middle <b>EMORY</b> Last <b>FRANKLIN</b>				4. DATE OF DEATH Month <b>11</b> -- Day <b>24</b> -- Year <b>19 57</b>			
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-8-1892</b>		9. AGE (In years last birthday) <b>65</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Miller (retired)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Feed mill</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Nathan Franklin</b>				14. MOTHER'S MAIDEN NAME <b>Olevia Barnes</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>W.W. 1 215-07-8894</b>		17. INFORMANT Address <b>Mrs. Annie Irene Franklin, same</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>976x Sunshot wound of head -</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>5 min</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>James T. Marsh</b> EXAMINER'S NAME (Type) <b>JAMES T. MARSH</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>11-26-1957</b>		22c. NAME OF CEMETERY <b>Morgan Chapel</b>		22d. LOCATION (City, town, or county) (State) <b>Carroll Co., Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. M. Waltz,</b> ADDRESS <b>Winfield, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>11/27/57</b>		24b. REGISTRAR'S SIGNATURE <b>Edna Smith</b>	

DATE SIGNED

11/24/57

RECEIVED

NOV 27 1957

BURKAV Y. S.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]  
AGE: [illegible]  
SEX: [illegible]  
RACE: [illegible]  
DATE OF DEATH: [illegible]  
PLACE OF DEATH: [illegible]  
CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
SIGNATURE OF EXAMINER: [illegible]  
DATE: [illegible]

CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Henryton</b>		c. LENGTH OF STAY IN 1b <b>1,276 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Henryton State Hospital</b>		d. STREET ADDRESS <b>1710 N. Monroe Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Thelma</b> Middle <b>Green</b> Last <b>Green</b>		4. DATE OF DEATH Month <b>November</b> Day <b>1</b> Year <b>19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 24, 1933</b>
9. AGE (In years lost birthday) <b>24 yrs.</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Walterboro, S. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Henry Washington</b>		14. MOTHER'S MAIDEN NAME <b>Elma Simmons</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Thelma Green</b>		Address <b>1710 N. Monroe Street</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage</b> <b>002X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Far adv. bilat. cavitary pulmonary tuberculosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>May 5, 1954</b> , to <b>November 1, 19 57</b> , that I last saw the deceased alive on <b>November 1, 19 57</b> , and that death occurred at <b>5:10A M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Henryton, Maryland</b> DATE SIGNED <b>11-1-57</b>			
ACTUAL SIGNATURE <b>E. M. Maculans</b> M.D.		PHYSICIAN'S NAME (Type) <b>Edgars M. Maculans, M. D., Supt. Henryton State Hospital</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11-6-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Mount Carmel</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles R. Law</b> ADDRESS <b>802 Madison Baltimore</b>		24a. REC'D BY REGISTRAR DATE <b>11-1-57</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur R. Smith</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

BUREAU V. S.

NOV 4 1957



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
SM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
11725 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 11731

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>7mos. 11days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Susan Catherine</b> Middle <b>HARE</b> Last				4. DATE OF DEATH Month <b>November</b> Day <b>2,</b> Year <b>1957</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>March 24, 1894</b>	9. AGE (in years last birthday) <b>63</b> yrs.	IF UNDER 1 YEAR Months <b>63</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Henry Hare</b>				14. MOTHER'S MAIDEN NAME <b>Harriet Rebecca Hare</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT Address <b>Springfield Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> 902.7 DUE TO Diabetes Mellitus Conditions, if any, which gave rise to immediate cause (b) <b>-</b> DUE TO C.B.S. assoc. with cerebral arteriosclerosis and diabetes with psychotic reaction. Fracture of skull. 262X (c)							INTERVAL BETWEEN ONSET AND DEATH <b>Years</b> <b>Years</b>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Patient fell out of bed sustaining fracture of skull.</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>11/2/57</b> 19 p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hospital</b>	20f. (City or town) <b>Sykesville</b>	(County) <b>Carroll</b>	(State) <b>Md.</b>		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>James T. Marsh</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>James T. Marsh, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-6-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Jr.</b>				24a. REC'D BY REGISTRAR <b>11-3-57</b>		24b. REGISTRAR'S SIGNATURE <b>C. Harry Ewen</b>	

MEDICAL CERTIFICATION

RECEIVED

NOV 29 1957

BUREAU V. S.

NON STATE  
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11732

11726

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Taneytown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Taneytown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First <u>Clarence</u> Middle <u>Herbert</u> Last <u>Hawk</u>				4. DATE OF DEATH Month <u>November</u> Day <u>24</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 5, 1884</u>		9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Nelson Hawk</u>				14. MOTHER'S MAIDEN NAME <u>Mary Harner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>215-18-1781</u>		17. INFORMANT <u>Mr. Kenneth Hawk, Taneytown, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (b) <u>arricular fibrillation</u> DUE TO (c) <u>3 yrs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>several years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1956</u> to <u>Nov 24, 1957</u> , that I last saw the deceased alive on <u>Nov 23 1957</u> , and that death occurred at <u>6:00</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W.R. Cadd</u>		M.D. <u>Emmily Mae</u>		ADDRESS (Street, city or town, state) <u>11-25-57</u>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>W R CADD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/26/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lutheran Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Taneytown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. R. Cadd</u> C. O. Fiss & Son				ADDRESS <u>Taneytown, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>Nov 27 57</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. R. Cadd</u>			

BUREAU A. 2

1957 20 100

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11727 CERTIFICATE OF DEATH

11733

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>3 mos. 27 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Springfield State Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>1321 N. Calvert Street</b> <b>3 Vol. 4</b>	
4. DATE OF DEATH Month <b>November</b> Day <b>19</b> Year <b>1957</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Sonia</b> Middle <b>Marinoff</b> Last <b>HEALD</b>		4. DATE OF DEATH Month <b>November</b> Day <b>19</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 20, 1890</b>
9. AGE (In years last birthday) <b>67</b> yrs.		IF UNDER 1 YEAR Months <b>67</b> Days <b>67</b> Hours <b>67</b> Min. <b>67</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>Russia</b>	
13. FATHER'S NAME <b>Michael Marinoff</b>		14. MOTHER'S MAIDEN NAME <b>Sonia Marinoff</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>-</b> DUE TO (c) <b>-</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Sociopathic personality disturbance. Drug Addiction.</b> INTERVAL BETWEEN ONSET AND DEATH <b>years</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>19</b> Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 22, 1957</b> , to <b>November 19, 1957</b> , that I last saw the deceased alive on <b>November 19, 1957</b> , and that death occurred at <b>12:15 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>11/19/57</b>			
ACTUAL SIGNATURE <b>Walther H. Sonnenfeldt</b> M.D.		DATE SIGNED <b>11/19/57</b>	
PHYSICIAN'S NAME (Type) <b>Walther H. Sonnenfeldt, M.D.</b>		Sykesville, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/23/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cathedral Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Peter Wiedefeld</b>		24a. REG'D BY REGISTRAR <b>NOV 22 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>C. Harry Weer</b>		DATE	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

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**BUREAU V. S.**

NOV 22 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

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VS. A15ME  
SM 2/57

11728 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11734

74

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>6 hours</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Edgar</b> Last <b>Hood</b>		4. DATE OF DEATH Month <b>11</b> Day <b>27</b> Year <b>19 57</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12 - 8 - 10</b>
9. AGE (In years last birthday) <b>46</b> yrs.		IF UNDER 1 YEAR Months <b>11</b> Days <b>27</b>	IF UNDER 24 HRS. Hours <b>19</b> Min. <b>57</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>shipping dept.</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Harry Hood</b>	
14. MOTHER'S MAIDEN NAME <b>Mamie Sschafer</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unkn</b>	
16. SOCIAL SECURITY NO. <b>215-10-4037</b>		17. INFORMANT <b>S.S.Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Brochopneumonia</b> <b>491X</b> <del>Xxxxx</del> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) <b>Starvation</b> DUE TO (c) <b>Schizophrenia catatonic type</b>		INTERVAL BETWEEN ONSET AND DEATH <b>days ?</b> <b>weeks ?</b>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>19</b> <b>p. m.</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James T. Marsh</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>James T. Marsh</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>11/28/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>12/2/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>LOUDON PARK</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C.F. Hoffmann</b>		24a. REC'D BY REGISTRAR <b>DEC 2</b>	
ADDRESS <b>3218 HUDSON ST.</b>		24b. REGISTRAR'S SIGNATURE <b>Darryl Shep</b>	

STATE DEPARTMENT OF HEALTH - BIRMINGHAM  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE  
 DEPT

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death	
John Doe		45		Male		White		12-1-1917		Home	
Cause of Death		Disease		Symptoms		Duration		Time of Day		Time of Year	
Heart Disease		Myocardial Infarction		Chest Pain		2 Weeks		11:00 AM		Winter	
Occupation		Education		Marital Status		Previous Illnesses		Heredity		Alcohol	
Clerk		High School		Married		None		None		None	
Signature of Examiner		Signature of Physician		Signature of Coroner		Signature of Registrar		Signature of Witness		Signature of Burial Officer	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

RECEIVED

BUREAU V. S.

DEC 2 1917

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11735

11729

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>CARROLL</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TANEYTOWN</b>				c. LENGTH OF STAY IN 1b <b>3 yrs</b>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>x2 TANEYTOWN</b>					
				d. STREET ADDRESS <b>W. BALTO. ST.</b>					
e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <del>HYER</del> <b>NETTIE</b> Middle <b>VIRGINIA</b> Last <b>HYER</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>9</b> Year <b>1957</b>					
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>SEPT. 6, 1885</b>			
9. AGE (In years last birthday) <b>72 yrs.</b>		IF UNDER 1 YEAR Months <b>72</b> Days <b>72</b> Hours <b>72</b> Min. <b>72</b>		IF UNDER 24 HRS. Months <b>72</b> Days <b>72</b> Hours <b>72</b> Min. <b>72</b>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House work</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>OWN Home</b>					
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>John CARL</b>				14. MOTHER'S MAIDEN NAME <b>MARGARET SLOAKER</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>218-09-2240</b>					
17. INFORMANT <b>LUTHER HALTER</b>				Address <b>TANEYTOWN MD.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary artery disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>a.s.c.v. disease</b> (c) <b>420.1</b> DUE TO (a) <b>420.1</b> (b) <b>a.s.c.v. disease</b> (c) <b>420.1</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>420.1</b>								INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs</b> <b>yr.</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <b>o. m.</b> <b>p. m.</b> <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				20g. (County)		20h. (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <b>James J. Marsh</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <b>JAMES T MARSH</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				22b. DATE THEREOF <b>11/13/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>MAY BERRY CEMETERY</b>			
22d. LOCATION (City, town, or county)				22e. (State)		22f. (County)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Merwyn C. Foss</b>				ADDRESS <b>TANEYTOWN, MD.</b>		24a. REC'D BY REGISTRAR <b>Nov 12 57</b>			
24b. REGISTRAR'S SIGNATURE <b>Decker</b>				24c. (City or town)		24d. (County)			

BUREAU V. S.

NOV 12 1957

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 8 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 11 Film G223 12-12-57 et

11730

CERTIFICATE OF DEATH

11736

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>1 ml3 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 11, Md.</b> <b>3 v o 1.4</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>1407 Weldon Place</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Frederick</b> Middle <b>Earl</b> Last <b>Johnson</b>				4. DATE OF DEATH Month <b>11</b> Day <b>30</b> Year <b>19 57</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-15-93</b>	
9. AGE (In years last birthday) <b>64</b> yrs.		IF UNDER 1 YEAR Months <b>64</b> Days <b>64</b> Hours <b>64</b> Min. <b>64</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Police Dept.</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Andrew Johnson</b>				14. MOTHER'S MAIDEN NAME <b>Carrie (Unknown)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>unkn</b>				16. SOCIAL SECURITY NO. <b>unkn</b>		17. INFORMANT <b>Springf. State Hospit. Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>422.1</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chr. brain syndr. assoc. with cerebr. arterioscler. with psych. reaction</b> INTERVAL BETWEEN ONSET AND DEATH <b>years</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>19</b> a. m. p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>10-17</b> , 19 <b>57</b> , to <b>11-29</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>11-29</b> , 19 <b>57</b> , and that death occurred at <b>4:25 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>11-30-57</b>							
ACTUAL SIGNATURE <b>Edmund Lusthaus</b> M.D.				DATE SIGNED <b>11-30-57</b>			
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus M.D.</b>				SYKESVILLE, MARYLAND.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>12/3/57</b>		<b>Woodlawn</b>		<b>Woodlawn Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Austin C. Donovan</b>				ADDRESS <b>3818 Roland Ave</b>		24a. REC'D BY REGISTRAR DATE <b>12/3/57</b>	
						24b. REGISTRAR'S SIGNATURE <b>C. Harry Meery</b>	

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is oriented horizontally but contains vertical text labels for various fields.

BUREAU V. 2

DEC 3 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# 1 11731 11731 CERTIFICATE OF DEATH 11737 Reg. Dist. No. 26 1 M 00 I 0 0 1 VS A15 (4) 15M 9/55

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Nr. Westminster</b>		c. LENGTH OF STAY IN 1b <b>40 Yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Westminster, Md. R. D. 1</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Elizabeth</b> Last <b>Jones</b>		4. DATE OF DEATH Month <b>November</b> Day <b>15</b> Year <b>19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 2, 1896</b>
9. AGE (In years last birthday) yrs. <b>61</b>		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife, Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Frederick Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Marshall Grimes</b>		14. MOTHER'S MAIDEN NAME <b>Rosa Pool</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>George D. Jones</b> Address <b>George D. Jones, R.D.1, Westminster, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Diabetic Coma</b> 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Diabetes, Nephritis, Cardiac Disease</b> DUE TO (c) <b>Nephritis, Cardiac Disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Nephritis, Cardiac Disease</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 days</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug 15, 1957</b> to <b>Nov 15, 1957</b> , that I last saw the deceased alive on <b>Nov 15, 1957</b> , and that death occurred at <b>2:30P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>George P. Ard</b> M.D.		ADDRESS (Street, city or town, state) <b>139 Cahole St, Hanover, Pa.</b>	
PHYSICIAN'S NAME (Type) <b>George P. Ard</b>		DATE SIGNED <b>Nov 15, 1957</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/18/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hanover, York County, Penna.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Richard A. Little</b> ADDRESS <b>Littlestown, Pa.</b>		24a. REC'D BY REGISTRAR <b>DATE 11-18-57</b>	
24b. REGISTRAR'S SIGNATURE <b>Harriet Miller</b>			

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

DATE OF DEATH

MARYLAND

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BUREAU V. 3

NOV 20 1957

RECEIVED

Richard A. Little

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11738

## 11732 CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN TB <b>14 mos.</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>27 Westminister</b>		d. STREET ADDRESS <b>1</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>A.</b> Last <b>Leister</b>		4. DATE OF DEATH Month <b>November</b> Day <b>14</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 1882</b>
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Leister</b>		14. MOTHER'S MAIDEN NAME <b>Frances Guy</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>unk.</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobar pneumonia</b> <b>490X</b> not DUE TO <b>arterioclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>generalized arteriosclerosis</b> (c) <b>years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic brain syndrome associated with disturbance of metabolism, growth or nutrition with senile brain disease with psychotic reaction</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept. 26</b> , 19 <b>55</b> , to <b>Nov. 14</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>November 14</b> , 19 <b>57</b> , and that death occurred at <b>6:00 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Walther H. Sonnenfeldt</b> M.D.		ADDRESS (Street, city or town, state) <b>Sykesville, Md.</b> DATE SIGNED <b>11/15/57</b>	
PHYSICIAN'S NAME (Type) <b>Walther H. Sonnenfeldt, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11-21-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Springfield</b>	22d. LOCATION (City, town, or county) (State) <b>Sykesville, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur H. Haight</b> ADDRESS <b>Sykesville, Md.</b>		24a. REC'D BY REGISTRAR <b>C. Harry Weer</b> DATE <b>11-21-57</b>	
24b. REGISTRAR'S SIGNATURE			



CERTIFICATE OF DEATH

Reg. No. 10

Form with multiple sections for recording death information, including fields for name, date, cause of death, and registrar details. The form is oriented horizontally but contains vertical text labels for various fields.

RECEIVED  
NOV 28 1957  
BUREAU V. S.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11733

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11733

Reg. Dist. No. 216

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. LENGTH OF STAY IN TB <u>2yrs.6mos.2days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wood Acres</u>		15 x 2.2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>		d. STREET ADDRESS <u>6009 Cobalt Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Agnes Alice Lockhart LENNOX</u>		4. DATE OF DEATH Month Day Year <u>November 11, 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 29, 1883</u>
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>74</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>South Dakota</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Lockhart</u>		14. MOTHER'S MAIDEN NAME <u>Alice Taft</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT <u>Springfield Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>491X</u> <del>XXXX</del> Conditions, if any, which gave rise to immediate cause (b) <u>Decubitus ulcers</u> [a], stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>C.B.S. assoc. with dist. of metabolism, growth, or nutrition, with senile brain dis., with psychotic reaction. Fracture, right hip.</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. <u>9047</u> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Patient fell while being dressed.</u> 20c. TIME OF INJURY Month, Day, Year <u>7:00</u> A.M. <u>10/27/</u> 19 <u>57</u> 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Hospital</u> 20f. (City or town) (County) (State) <u>Sykesville Carroll Md.</u> 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>James T. Marsh</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <u>James T. Marsh, M.D.</u> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>BURIAL</u> 22b. DATE THEREOF <u>11-15-57</u> 22c. NAME OF CEMETERY OR CREMATORY <u>OAKWOOD CEMETERY</u> 22d. LOCATION (City, town, or county) (State) <u>AUSTIN, MINNESOTA</u> 23. FUNERAL DIRECTOR'S SIGNATURE <u>Rev. Funeral Home 2224 N. Washington D.C.</u> 24a. REC'D BY REGISTRAR <u>11-20-57</u> 24b. REGISTRAR'S SIGNATURE <u>C. Harry Heers</u>			

**BUREAU V. S.**

NOV 25 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11740

## 11734 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>2mos. 21days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> 15-56.2 ✓			
f. STREET ADDRESS <b>9903 Woodland Drive</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>Greenberg</b> Last <b>LIPOV</b>				4. DATE OF DEATH Month <b>November</b> Day <b>26,</b> Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July, 1883</b>	
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>15</b> Hours <b>0</b> Min.		11. IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>			
11. BIRTHPLACE (State or foreign country) <b>Russia</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Sam Greenberg</b>				14. MOTHER'S MAIDEN NAME <b>Jane Greenberg</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>-</b>				16. SOCIAL SECURITY NO. <b>-</b>			
17. INFORMANT <b>Springfield Hospital Records</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>Generalized Arteriosclerosis</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. due to arteriosclerosis</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Sept. 5, 1957</b> to <b>November 26, 1957</b> , that I last saw the deceased alive on <b>November 25, 1957</b> , and that death occurred at <b>5:45 A. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield Hospital Records</b> DATE SIGNED <b>11/26/57</b>							
ACTUAL SIGNATURE <b>Walther H. Sonnenfeldt</b> M.D. <b>Springfield Hospital Records</b> 11/26/57							
PHYSICIAN'S NAME (Type) <b>Walther H. Sonnenfeldt, M.D.</b> <b>Sykesville, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>11/27/57</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>ELESAVET GRAD CEM.</b>				22d. LOCATION (City, town, or county) (State) <b>MD</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Greer Funeral Home 4217-9<sup>th</sup> Ave NW</b>							
24a. REC'D BY REGISTRAR <b>DATE 11/27/1957</b>							
24b. REGISTRAR'S SIGNATURE <b>C. Harry Weer</b>							

RECEIVED



## 11735 CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>10 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>2126 St. Paul St.</b> <b>Baltimore/186/166</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Axel</b> Middle <b>William</b> Last <b>MALMGREN</b>				4. DATE OF DEATH Month <b>November</b> Day <b>2</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1/8/94</b>	
9. AGE (In years last birthday) <b>63</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Sweden</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Axel Malmgren</b>				14. MOTHER'S MAIDEN NAME <b>Elise -</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No -</b>		16. SOCIAL SECURITY NO. <b>214-01-7762</b>		17. INFORMANT Address <b>Springfield Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. associated with arteriosclerosis, with psychosis.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>October 23, 1957</b> to <b>November 2, 1957</b> , that I last saw the deceased alive on <b>November 1, 1957</b> , and that death occurred at <b>2:02 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>11/2/57</b> ACTUAL SIGNATURE <b>Edmund Lusthays</b> M.D. <b>Springfield State Hospital</b> PHYSICIAN'S NAME (Type) <b>Edmund Lusthays</b> <b>Sykesville, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>11/5/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Crematory</b>		22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WILLIAM J. TICKNER &amp; SONS - Balto., Md.</b>				24a. REC'D BY REGISTRAR DATE <b>11/5/57</b>		24b. REGISTRAR'S SIGNATURE <b>C. Harry Myers</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH 1957		PLACE OF DEATH BALTIMORE	
AGE 30 days		SEX MALE	
RACE WHITE		EDUCATION HIGH SCHOOL	
OCCUPATION HOUSEWIFE		MARRIAGE MARRIED	
DATE OF BIRTH 1927		PLACE OF BIRTH BALTIMORE	
MOTHER'S NAME JANE		FATHER'S NAME JOHN	
MARRIAGE MARRIED		DATE OF MARRIAGE 1950	
PLACE OF MARRIAGE BALTIMORE		MARRIAGE MARRIED	
DATE OF DEATH 1957		PLACE OF DEATH BALTIMORE	
AGE 30 days		SEX MALE	
RACE WHITE		EDUCATION HIGH SCHOOL	
OCCUPATION HOUSEWIFE		MARRIAGE MARRIED	
DATE OF BIRTH 1927		PLACE OF BIRTH BALTIMORE	
MOTHER'S NAME JANE		FATHER'S NAME JOHN	
MARRIAGE MARRIED		DATE OF MARRIAGE 1950	
PLACE OF MARRIAGE BALTIMORE		MARRIAGE MARRIED	

CAUSE OF DEATH Sudden death		MANNER OF DEATH NATURAL	
DATE OF DEATH 1957		PLACE OF DEATH BALTIMORE	
AGE 30 days		SEX MALE	
RACE WHITE		EDUCATION HIGH SCHOOL	
OCCUPATION HOUSEWIFE		MARRIAGE MARRIED	
DATE OF BIRTH 1927		PLACE OF BIRTH BALTIMORE	
MOTHER'S NAME JANE		FATHER'S NAME JOHN	
MARRIAGE MARRIED		DATE OF MARRIAGE 1950	
PLACE OF MARRIAGE BALTIMORE		MARRIAGE MARRIED	

BUREAU V. E.

NOV 6 1957

RECEIVED

## 11736 CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u>		c. LENGTH OF STAY IN 1b <u>since 10-22-54</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Springfield State Hospital</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Route #2 - Taneytown X 2</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>George Benjamin MARSHALL, Sr.</u>		4. DATE OF DEATH Month Day Year <u>November 12 1957</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 26, 1877</u>
9. AGE (In years lost birthday) <u>80</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Night watchman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>176-07-9666</u>	
11. BIRTHPLACE (State or foreign country) <u>Carroll Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>David A. Marshall</u>		14. MOTHER'S MAIDEN NAME <u>Caroline Secrist</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Records of Springfield State Hospital</u>		Address <u>Sykesville, Md.</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>years</u> <u>more than 3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19 _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) (County) (State) _____
21. I certify that I attended the deceased from <u>Dec. 27</u> , 19 <u>54</u> , to <u>Nov. 11</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov. 11</u> , 19 <u>57</u> , and that death occurred at <u>1:50 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Martin Gross</u> M.D. <u>Springfield State Hospital</u> <u>11-12-57</u> PHYSICIAN'S NAME (Type) <u>Martin Gross, M. D.</u> <u>Sykesville, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/16/1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Eastern Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Taneytown Rd. Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. O. Ransom</u>		24a. REC'D BY REGISTRAR <u>NOV 14 1957</u>	24b. REGISTRAR'S SIGNATURE <u>C. Harry Keays</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11743

11737

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

74

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Carroll</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u> City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. LENGTH OF STAY IN 1b <u>45yrs. 1mos. 4days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <span style="float: right;">3V01.4</span>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>				d. STREET ADDRESS <u>(Bay View Hospital)</u>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Lizzie</u> Middle <u>MARTIN</u> Last <u>MARTIN</u>				<b>4. DATE OF DEATH</b> Month <u>November</u> Day <u>19</u> Year <u>1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1872 ?</u>	9. AGE (In years last birthday) <u>85 ?</u> yrs.	IF UNDER 1 YEAR      IF UNDER 24 HRS. Months      Days      Hours      Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>York</u>		17. INFORMANT Address <u>Springfield Hospital Records</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage from an ulcer in the esophagus</u> DUE TO <u>5391</u> Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. DUE TO _____ (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>Mental deficiency, undifferentiated.</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m.      p. m.      19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>James T. Marsh</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>11/19/57</u>			
EXAMINER'S NAME (Type) <u>James T. Marsh, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-22-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Springfield Hospital</u>			
22d. LOCATION (City, town, or county) (State) <u>Sykesville, Md.</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Haight</u>		ADDRESS <u>Sykesville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>11-22-57</u>			
24b. REGISTRAR'S SIGNATURE <u>C. H. H. H.</u>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



RECEIVED

## 11738 CERTIFICATE OF DEATH

11744

Reg. Dist. No.

75

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Melrose</u>		c. LENGTH OF STAY IN 1b <u>75 yrs</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Melrose</u>		x2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Manchester P.O.</u>		d. STREET ADDRESS <u>Manchester P.O.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>IDA</u> Middle <u>YINGLING</u> Last <u>MONTHATH</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>19</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 14, 1876</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William H. Yingling</u>		14. MOTHER'S MAIDEN NAME <u>Mary E. Sullivan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-12-1197</u>	
17. INFORMANT <u>Wesley Monthath</u>		Address <u>Manchester, MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Rt. Breast</u> 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>7 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 18, 1950</u> to <u>Nov. 19, 1957</u> , that I last saw the deceased alive on <u>Nov. 18, 1957</u> , and that death occurred at <u>12:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M.C. Porterfield</u> M.D.		ADDRESS (Street, city or town, state) <u>Hampstead, Md.</u> DATE SIGNED <u>Nov 21/57</u>	
PHYSICIAN'S NAME (Type) <u>M.C. Porterfield</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov. 22, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven</u>	22d. LOCATION (City, town, or county) (State) <u>Hanover Pa</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>McGehee</u>		ADDRESS <u>Glenn Road, Pa</u>	
24a. REC'D BY REGISTRAR <u>Wesley Monthath</u>		24b. REGISTRAR'S SIGNATURE <u>Wesley Monthath</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

NOV 22 1957

**BUREAU V. S.**

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11739

## CERTIFICATE OF DEATH

11745

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MD</b> b. COUNTY <b>Ashbury METHODIST Home Gaithersbury</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville, Md</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersbury</b> formerly of: <b>Kingsley Rd. 03x0.2</b>			
c. LENGTH OF STAY IN Ib <b>2 yrs, 1 mos</b>				d. STREET ADDRESS <b>Ashbury Methodist Home</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				7 days			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Catherine (Kate) Lee Morgan</b>				4. DATE OF DEATH Month Day Year <b>11 16 1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-28-64</b>	
9. AGE (In years last birthday) <b>93</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>house-keeper</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>William Morgan</b>				14. MOTHER'S MAIDEN NAME <b>Margaret E. Murray</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <b>Hospital Records— Sykesville, Md</b>				Address			
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).}							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO <b>(3 d grade)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cardiovascular disease/with decompensation</b> DUE TO <b>Arteriosclerosis, Disturbance of Metabolism,</b> (c) <b>10-31-57 till 11-16-57.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CHRONIC BRAIN SYNDROME ASSOCIATED WITH ICNILE BRAIN DISEASE.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>11-10</b> , 19 <b>55</b> , to <b>11-16</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>11-16</b> , 19 <b>57</b> , and that death occurred at <b>9:10 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Julian Radzykewycz</b>				DATE SIGNED <b>Springfield State Hosp. Sykesville, Md.</b>			
PHYSICIAN'S NAME (Type) <b>JULIAN RADZYKEWYCZ</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/19/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Westminster Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Westminster, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>WILLIAM J. TICKNER &amp; SONS</b>				24a. REC'D BY REGISTRAR <b>NOV 20 1957</b>			
24b. REGISTRAR'S SIGNATURE <b>C. Harry Myers</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]	
AGE [Faint text, possibly "45 years"]		DATE OF BIRTH [Faint text, possibly "Jan 15, 1912"]	
PLACE OF BIRTH [Faint text, possibly "Baltimore, Md"]		OCCUPATION [Faint text, possibly "Teacher"]	
MARITAL STATUS [Faint text, possibly "Married"]		DATE OF DEATH [Faint text, possibly "Nov 10, 1957"]	
CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		PLACE OF DEATH [Faint text, possibly "Home"]	
SIGNATURE OF PHYSICIAN [Faint signature]		SIGNATURE OF REGISTRAR [Faint signature]	
DATE OF SIGNATURE [Faint text, possibly "Nov 10, 1957"]		DATE OF SIGNATURE [Faint text, possibly "Nov 10, 1957"]	

BUREAU V. S.

NOV 20 1957

RECEIVED



## : 11740 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u>				c. LENGTH OF STAY IN 1b <u>since 9-25-43</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lonaconing</u> <u>01x2.2</u>				d. STREET ADDRESS <u>Railroad Street</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Paul</u> Middle <u>Vernon</u> Last <u>MORGAN</u>				4. DATE OF DEATH Month <u>November</u> Day <u>16</u> Year <u>1957</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 14, 1890</u>	9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	IF UNDER 24 HRS. Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Work</u>		11. BIRTHPLACE (State or foreign country) <u>Lonaconing, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Esau Morgan</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Rinker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT <u>Records of Springfield State Hospital</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>420.0</u> not DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>days</u> <u>years</u> <u>years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Arteriosclerosis with paranoid coloring</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>—</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>—</u> p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>	
20f. (City or town) <u>—</u>				20g. (County) <u>—</u>		20h. (State) <u>—</u>	
21. I certify that I attended the deceased from <u>11-14-</u> 19 <u>57</u> , to <u>11-16-</u> 19 <u>57</u> , that I last saw the deceased alive on <u>11-16-</u> 19 <u>57</u> , and that death occurred at <u>5.34 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Agustin del Campo</u> M.D.				ADDRESS (Street, city or town, state) <u>Springfield State Hospital.</u>			
DATE SIGNED <u>11-16-57</u>							
PHYSICIAN'S NAME (Type) <u>Agustin del Campo. M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-19-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lonaconing</u>		22d. LOCATION (City, town, or county) (State) <u>Lonaconing, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Eichorn Funeral Home</u>				ADDRESS <u>Lonaconing, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>11-16-57</u>	
				24b. REGISTRAR'S SIGNATURE <u>C. Henry</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 12

**BUREAU V. S.**

NOV 19 1957

RECEIVED

11741

## CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sykesville</i>				c. LENGTH OF STAY IN 1b <i>1 y 10 mo 8 days</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Springfield State Hospital</i>				d. STREET ADDRESS <i>6 Kenwood Ave</i>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>Katherine Agnes Murphy</i>				4. DATE OF DEATH Month Day Year <i>Nov. 25 1957</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>not known</i>	
9. AGE (In years last birthday) <i>81 1/2 yrs.</i>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>							
13. FATHER'S NAME <i>John Charles Murphy</i>				14. MOTHER'S MAIDEN NAME <i>Bridget Scally</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>				16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT <i>Hospital records</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchopneumonia</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____				INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>C. B. S. ass. with circulatory disturbance, cerebral arteriosclerosis, with psychosis</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I of Form 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>1-17</i> , 19 <i>56</i> , to <i>11-25</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>11-24</i> , 19 <i>57</i> , and that death occurred at <i>7:30</i> P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Walther H. Sonnenfeldt</i>				ADDRESS (Street, city or town, state) DATE SIGNED <i>Springfield State Hospital 11/25/57</i>			
PHYSICIAN'S NAME (Type) <i>Walther H. Sonnenfeldt</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Nov. 27, 1957</i>		22c. NAME OF CEMETERY OR CREMATORY <i>new Cathedral Cemt.</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John A. Moran</i>				ADDRESS <i>3000 E. Baltimore St.</i>		24a. REC'D BY REGISTRAR <i>NOV 29 1957</i>	
				24b. REGISTRAR'S SIGNATURE <i>C. Harry Kuro</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		1922		MOBILE, ALABAMA	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		MEDICAL ATTENDANT	
APRIL 4, 1968		MEMPHIS, TENNESSEE		SHOOTING		SUICIDE		GUNSHOT WOUNDS		DR. JAMES H. HAYES	
TIME OF DEATH		HOURS		MINUTES		SECOND		TEMPERATURE		PULSE	
10:00 AM		4		15		00		98.6		60	
DATE OF BURIAL		PLACE OF BURIAL		CITY		STATE		COUNTRY		CEMETERY	
APRIL 8, 1968		MEMPHIS		TENNESSEE		USA				SOUTH MEADOWS	
NAME OF FUNERAL HOME		ADDRESS		CITY		STATE		COUNTRY		PHONE	
JAMES EARL RAY FUNERAL HOME		1000 N. 3RD ST.		MEMPHIS		TENNESSEE		USA		925-1234	
NAME OF NEXT OF KIN		ADDRESS		CITY		STATE		COUNTRY		PHONE	
JAMES EARL RAY		1000 N. 3RD ST.		MEMPHIS		TENNESSEE		USA		925-1234	

BUREAU V. R.

NOV 29 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 13 Film 224 1-17-58 et

CERTIFICATE OF DEATH

117482

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Airy</u>		c. LENGTH OF STAY IN 1b <u>89 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home - E. Church st</u>		d. STREET ADDRESS <u>1 East Church Street</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Washington</u> Last <u>Nusbaum</u>		4. DATE OF DEATH Month <u>November</u> Day <u>7</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 1, 1868</u>
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>telegraph operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Philip Henry Nusbaum</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Snyder</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>705-07-7961</u>	
17. INFORMANT <u>Mrs. Helen Lowman (daughter)</u>		Address <u>Mt. Airy, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>181X Carcinoma of Bladder</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>7 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1955</u> , to <u>1957</u> , that I last saw the deceased alive on <u>September 5, 1957</u> , and that death occurred at <u>4 A.</u> M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W.B. Culwell</u> M.D.		ADDRESS (Street, city or town, state) <u>Mt. Airy, Md</u> DATE SIGNED <u>Nov. 7, 1957</u>	
PHYSICIAN'S NAME (Type) <u>W.B. Culwell</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>11-9-1957</u>	22c. NAME OF CEMETERY OR INTERMENT PLACE <u>Pine Grove</u>	22d. LOCATION (City, town, or county) (State) <u>Mt. Airy Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>C.M. Wertz</u> ADDRESS <u>Winfield, Md.</u>		24a. REC'D BY REGISTRAR <u>NOV 8 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Edna Smith</u>



CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>JOHN J. SMITH</i>		2. SEX <i>MALE</i>	
3. DATE OF BIRTH <i>1915</i>		4. PLACE OF BIRTH <i>NEW YORK</i>	
5. OCCUPATION <i>LABORER</i>		6. MARITAL STATUS <i>MARRIED</i>	
7. PLACE OF DEATH <i>HOME</i>		8. CAUSE OF DEATH <i>HEART DISEASE</i>	
9. DATE OF DEATH <i>NOV 10 1957</i>		10. TIME OF DEATH <i>10:00 AM</i>	
11. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		12. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
13. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		14. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
15. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		16. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
17. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		18. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
19. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		20. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
21. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		22. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
23. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		24. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
25. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		26. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
27. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		28. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
29. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		30. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
31. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		32. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
33. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		34. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
35. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		36. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
37. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		38. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
39. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		40. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
41. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		42. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
43. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		44. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
45. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		46. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
47. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		48. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
49. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		50. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
51. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		52. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
53. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		54. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
55. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		56. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
57. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		58. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
59. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		60. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
61. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		62. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
63. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		64. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
65. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		66. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
67. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		68. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
69. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		70. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
71. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		72. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
73. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		74. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
75. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		76. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
77. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		78. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
79. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		80. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
81. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		82. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
83. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		84. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
85. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		86. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
87. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		88. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
89. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		90. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
91. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		92. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
93. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		94. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
95. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		96. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
97. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		98. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	
99. SIGNATURE OF DECEASED <i>JOHN J. SMITH</i>		100. SIGNATURE OF WITNESS <i>JOHN J. SMITH</i>	

RECEIVED  
NOV 8 1957  
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11749

## CERTIFICATE OF DEATH

Reg. Dist. No.

74

11743

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>1yr.6days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>-</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Harris</b> Last <b>O'BRIEN</b>				4. DATE OF DEATH Month <b>November</b> Day <b>22</b> Year <b>1957</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 8, 1872</b>	9. AGE (In years last birthday) <b>85</b> yrs.	IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Agriculture</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Daniel O'Brien</b>				14. MOTHER'S MAIDEN NAME <b>Mary Pritts</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>-</b>		16. SOCIAL SECURITY NO. <b>unk</b>		17. INFORMANT Address <b>Springfield State Hospital</b>			
18. CAUSE OF DEATH [Enter only one cause per line far (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary insufficiency</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>Generalized arteriosclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b> <b>Years</b> <b>Years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. associated with circ. dist. with cerebral arteriosclerosis, with psychotic reaction.</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <b></b> a. m. <b>19</b> p. m. <b></b>	Month, <b></b>	Day, <b></b>	Year, <b></b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11/16/56</b> , 19 <b></b> , to <b>11/22/57</b> , 19 <b></b> , that I last saw the deceased alive on <b>11/22/57</b> , 19 <b></b> , and that death occurred at <b>6:15P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>11/23/57</b>							
ACTUAL SIGNATURE <b>Agustin del Campo</b> M.D.				DATE SIGNED <b>11/23/57</b>			
PHYSICIAN'S NAME (Type) <b>Agustin del Campo, MD</b>				Sykesville, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11-26-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Westernport</b>		22d. LOCATION (City, town, or county) (State) <b>Westernport, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Boal Funeral Home - Westernport, Md.</b> ADDRESS <b>Westernport, Md.</b>				24a. REC'D BY REGISTRAR <b>C. Harry Wheeler</b>	24b. REGISTRAR'S SIGNATURE <b>C. Harry Wheeler</b>		

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

1957

BUREAU V. 1

NOV 26 1957

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No. 74

11744

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN TB <b>19 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>-</b>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Hugh</b> Last <b>ORR</b>				4. DATE OF DEATH Month <b>November</b> Day <b>27</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 25, 1885</b>	
9. AGE (In years last birthday) <b>72</b> yrs.		IF UNDER 1 YEAR Months <b>72</b> Days <b>27</b> Hours <b>19</b> Min.		IF UNDER 24 HRS. Months <b>72</b> Days <b>27</b> Hours <b>19</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Drug Clerk</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>- Ynk.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Hugh Orr</b>				14. MOTHER'S MAIDEN NAME <b>Isabel McFarland</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>Ynk.</b>		17. INFORMANT <b>Springfield Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lobar pneumonia</b> DUE TO (b) <b>Malnutrition</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <b>C.B.S. associated with cerebral arteriosclerosis.</b>				INTERVAL BETWEEN ONSET AND DEATH <b>Days</b> <b>Unknown</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <b>19</b> Day <b>19</b> Year <b>1957</b> Hour <b>a. m.</b> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Springfield</b>				20g. (County) <b>Allegany</b>		20h. (State) <b>West Virginia</b>	
21. I certify that I attended the deceased from <b>November 8, 1957</b> to <b>November 27, 1957</b> , that I last saw the deceased alive on <b>November 26, 1957</b> , and that death occurred at <b>6:25 A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Walther H. Sonnenfeldt</b>				ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>		DATE SIGNED <b>11/27/57</b>	
PHYSICIAN'S NAME (Type) <b>Walther H. Sonnenfeldt, M.D.</b>				SYNOPSIS <b>Sykesville, Maryland.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-30-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lonaconing</b>		22d. LOCATION (City, town, or county) (State) <b>Lonaconing, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Pickens Funeral Home</b>				ADDRESS <b>Lonaconing, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE 11-27-57</b>	
24b. REGISTRAR'S SIGNATURE <b>C. H. H. H. H.</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 5, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 7 and 8 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED



## CERTIFICATE OF DEATH

11751

Reg. Dist. No. 74

11745

1. PLACE OF DEATH o. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Henryton</b>				c. LENGTH OF STAY IN TB <b>2,089 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Henryton State Hospital</b>				d. STREET ADDRESS <b>858 Vine Street</b>			
3. NAME OF DECEASED (Type or print) First <b>Anderson</b> Middle <b>James</b> Last <b>Pearson</b>				4. DATE OF DEATH Month <b>November</b> Day <b>3</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>December 25, 1917</b>	
9. AGE (In years last birthday) <b>40</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Stevedore</b>		11. BIRTHPLACE (State or foreign country) <b>Hamlet, N. C.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Henry Pearson</b>				14. MOTHER'S MAIDEN NAME <b>Lucille Miles</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>W.W. 11 227-03-2032</b>		17. INFORMANT <b>Anderson J. Pearson - Patient</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardio-vascular insufficiency</b> <b>002X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Far Advanced bilateral cavitory pulmonary Tbc.</b> DUE TO (c) <b>Bronchial Asthma</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>February 14, 1952</b> , to <b>November 3, 1957</b> , that I last saw the deceased alive on <b>November 3, 1957</b> , and that death occurred at <b>11:10 P. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>E. M. Maculans</b>				ADDRESS (Street, city or town, state) <b>Henryton, Maryland</b>		DATE SIGNED <b>11-3-57</b>	
PHYSICIAN'S NAME (Type) <b>Edgars M. Maculans, M. D.; Supt. Henryton State Hospital</b>							
22a. BURIAL, CREMATION, or REMOVAL (Specify) <b>Burial Nov. 19, 1957</b>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <b>Dobbin Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hamlet N.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>McEachern Funeral Home</b>				ADDRESS <b>Hamlet N.C.</b>		24a. REC'D BY REGISTRAR <b>DATE 11-5-57</b>	
				24b. REGISTRAR'S SIGNATURE <b>Albert R. Swanthony</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

11752

11746

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>				c. LENGTH OF STAY IN 1b <u>YEARS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MAIN ST.</u>				d. STREET ADDRESS <u>MAIN ST</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>LESTER H PERRY</u>				4. DATE OF DEATH Month Day Year <u>NOV. 25 1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 2 - 1875</u>	9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TOWN CLERK</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM H PERRY</u>				14. MOTHER'S MAIDEN NAME <u>AMELIA HUNTER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>219-05-4767</u>		17. INFORMANT Address <u>NEYA G PERRY UNION BRIDGE MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 24, 1957</u> to <u>Nov 25</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov 25</u> , 19 <u>57</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. H. Legg</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>Union Bridge Md 11-25-57</u>			
PHYSICIAN'S NAME (Type) <u>Dr. T.H. Legg</u>				Union Bridge, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/28/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT. VIEW CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>UNION BRIDGE MD.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>R.D. Hatcher Union Bridge, Md</u>				24a. REC'D BY REGISTRAR DATE <u>Nov 27, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Lester S. Repp</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DOI: 10.1002/for

BUREAU V. S.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3, could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11753

## 11747 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>6yrs. 11mos. 7days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>330 Main St.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Miller</b> Last <b>PURDY</b>				4. DATE OF DEATH Month <b>November</b> Day <b>29</b> Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 9, 1874</b>	
9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months <b>83</b> Days <b>03</b> Hours <b>22</b> Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Milliner</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Y-nk</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>John Jacob Purdy</b>				14. MOTHER'S MAIDEN NAME <b>Mary Catherine Hare</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Y-nk</b>		17. INFORMANT <b>Springfield Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage due to hypertension</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>331x</b> (c) <b>260x</b>				INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Psychosis with cerebral arteriosclerosis &amp; diabetes</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>December 22, 1950</b> to <b>November 29, 1957</b> , that I last saw the deceased alive on <b>November 28, 1957</b> , and that death occurred at <b>12:45A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Walther H. Sonnenfeldt</b> M.D.				ADDRESS (Street, city or town, state) <b>Springfield Hospital</b>			
DATE SIGNED <b>11/29/57</b>							
PHYSICIAN'S NAME (Type) <b>Walther H. Sonnenfeldt, M.D.</b>				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-1-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Manchester</b>		22d. LOCATION (City, town, or county) (State) <b>Carroll Co Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edw A. Tipton</b>				ADDRESS <b>Hampstead Md</b>			
24a. REC'D BY REGISTRAR <b>C. Harry Weer</b>				24b. REGISTRAR'S SIGNATURE <b>C. Harry Weer</b>			



CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES EARL RAY		35		M		W		1922		MOBILE		ALABAMA		UNITED STATES		UNITED STATES	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
JANUARY 4, 1968		MEMPHIS		MEMPHIS		TENNESSEE		UNITED STATES		JANUARY 4, 1968		MEMPHIS		MEMPHIS		TENNESSEE	
TIME OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		ANATOMICAL SITE		TIME OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY	
10:00 PM		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		HEART		10:00 PM		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH	
JANUARY 4, 1968		MEMPHIS		MEMPHIS		TENNESSEE		UNITED STATES		JANUARY 4, 1968		MEMPHIS		MEMPHIS		TENNESSEE	
TIME OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY		ANATOMICAL SITE		TIME OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		DISEASE OR INJURY	
10:00 PM		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		HEART		10:00 PM		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE	

BUREAU V. R.

DEC 4 1957

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11748  
CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH o. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>1yr, 9mo, 21dys</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>2305 St. Paul Street</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle Last <b>Repp</b>		4. DATE OF DEATH Month <b>November</b> Day <b>4</b> Year <b>19 57</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 5, 1880</b>
9. AGE (In years last birthday) <b>77 yrs.</b>		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Examiner of garments</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Stadium Clothing Works Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>B. Henry Repp</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Amend</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-03-8701</b>	
17. INFORMANT <b>Springfield hospital records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CBS assoc. with circulatory disturbance, with cerebral arteriosclerosis, with psychotic reaction</b>			
INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>years</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January 13 1956</b> , to <b>November 4, 19 57</b> , that I last saw the deceased alive on <b>November 3, 19 57</b> , and that death occurred at <b>5:35 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Elizabeth Kuopp</b>		ADDRESS (Street, city or town, state) <b>Springfield State Hosp. Sykesville</b>	
PHYSICIAN'S NAME (Type) <b>Elizabeth Kuopp</b>		DATE SIGNED <b>Springfield State Hosp. Sykesville</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 6. 1957</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HENRY SANDER &amp; SONS, INC.</b>		ADDRESS <b>Baltimore Md.</b>	
24a. REC'D BY REGISTRAR <b>DATE 1-4-57</b>		24b. REGISTRAR'S SIGNATURE <b>C. Harry Allen</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 6 1957

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11749

CERTIFICATE OF DEATH

11755

Reg. Dist. No. 76

1. PLACE OF DEATH a. COUNTY <u>Carroll Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Meadow View Convalescent Home Silver River</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ELLEN - MINERVA - RINEHART</u>				4. DATE OF DEATH Month Day Year <u>Nov. 14th - 1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 29, 1873</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Canning factory</u>			
11. BIRTHPLACE (State or foreign country) <u>Littlestown Pa.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Levi D. Maus</u>				14. MOTHER'S MAIDEN NAME <u>Ludie A. Guntelins</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>215-14-2495</u>			
				17. INFORMANT <u>Mrs. Rinehart, Westminster, Md.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congestive Heart Failure</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Feb 15</u> , 1950, to <u>Nov 14</u> , 1957, that I last saw the deceased alive on <u>Nov 14</u> , 1957, and that death occurred at <u>8:25 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Julius Chepko</u>				DATE SIGNED <u>85 1/2 Western U.S. Mountain Md 11/14/57</u>			
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 16/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bowst Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Rural, Westminster Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr., Westminster, Md.</u> ADDRESS				24a. REC'D BY REGISTRAR <u>DATE 11-14-57</u>		24b. REGISTRAR'S SIGNATURE <u>Harriet Miller</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

VS. A15ME  
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11750

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11756

Reg. Dist. No. 114

1. PLACE OF DEATH o. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>2yrs. 4mos. 16days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		3V01-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>3310 W. Elm Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Martha Alice Shearer ROBERTSON</b>		4. DATE OF DEATH Month Day Year <b>November 25, 19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>March 10, 1870</b>
9. AGE (In years last birthday) <b>87</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <b>25, 19 57</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>VanBuren Shearer</b>		14. MOTHER'S MAIDEN NAME <b>Cecelia -</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>444</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sub-dural hematoma</b> <b>936.7</b> Bilateral pneumonia Conditions, if any, which gave rise to immediate cause (b) <b>Due to</b> (c) <b>C.B.S. assoc. with circ. dist. with cerebral arteriosclerosis with psychotic reaction.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>Days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with circ. dist. with cerebral arteriosclerosis with psychotic reaction.</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>Patient found lying on floor by her bed.</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>9:15</b> <b>11/23/ 19 57</b> Hour <del>9:15</del> a.m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work of work <b>Hospital</b>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hospital</b>		20f. (City or town) (County) (State) <b>Sykesville Carroll Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James T. Marsh</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>James T. Marsh, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>11/26/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-3-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Springfield Hospital</b>		22d. LOCATION (City, town, or county) (State) <b>Sykesville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur A. Haight</b>		24a. REC'D BY REGISTRAR <b>DATE 12-3-57</b>	
24b. REGISTRAR'S SIGNATURE <b>C. Harry Weir</b>			

FOR STATE  
HEALTH DEPT

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

DEC 6 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11757

11703

## CERTIFICATE OF DEATH

Reg. Dist. No.

76

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>				c. LENGTH OF STAY IN 1b <u>35 YRS.</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>				27			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>60 WESTMORELAND ST.</u>				d. STREET ADDRESS <u>60 WESTMORELAND AVE.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGARET JULIA ROOP</u>				4. DATE OF DEATH Month Day Year <u>NOV. 10 1957</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB. 14, 1875</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>dress-maker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>			
11. BIRTHPLACE (State or foreign country) <u>CARROLL CO. Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>WILLIAM A. ROOP</u>				14. MOTHER'S MAIDEN NAME <u>EMMA C. NORRIS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>213-3677</u>			
17. INFORMANT <u>MISS ELSIE E. ROOP, WESTMINSTER, MD.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>331x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>3 yrs +</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Jan. 1953</u> to <u>Nov. 10, 1957</u> that I last saw the deceased alive on <u>Nov. 7, 1957</u> , and that death occurred at <u>5:40 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town; state) <u>115 Kenilworth Ave Westminister Md.</u> DATE SIGNED <u>11/11/57</u>							
ACTUAL SIGNATURE <u>E. Reese Wilkens</u>							
PHYSICIAN'S NAME (Type) <u>Dr E. Reese Wilkens</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>NOV. 13, 57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PIPE CREEK CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>NEAR, NEWWINDSOR Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr., Westminister Md.</u>				24a. REC'D BY REGISTRAR <u>11-17-57</u>			
24b. REGISTRAR'S SIGNATURE <u>H. amick Miller</u>							

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		45		M		W		JAN 15 1892		BALTIMORE, MD.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH	
1234 E. BALTIMORE ST.		LABORER		HEART DISEASE		NATURAL		NOV 14 1957		BALTIMORE, MD.	
PREVIOUS ILLNESS		DATE OF ONSET		DATE OF DEATH		TIME OF DEATH		HOUR OF DEATH		MINUTE OF DEATH	
NONE		OCT 15 1957		NOV 14 1957		10:30 AM		10:30		30	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
DATE		TIME		PLACE		CITY		STATE		COUNTRY	
NOV 14 1957		10:30 AM		BALTIMORE		MD.		U.S.A.		U.S.A.	

BUREAU V. S.

NOV 14 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

11751

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11758

Reg. Dist. No. 44

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore City</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sykesville</i>		c. LENGTH OF STAY IN 1b <i>5y 27days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Springfield State Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Annæ May Smith</i>		4. DATE OF DEATH <i>Nov 10 1957</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July - 15 - 1888</i>
9. AGE (In years last birthday) <i>69 yrs.</i>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Menchere</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Ford</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>unk.</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>unk.</i>	
17. INFORMANT <i>Hospital records.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.0</i> DUE TO <i>Arteriosclerotic heart + disease</i> Conditions, if any, which gave rise to immediate cause (b) <i>Bronchopneumonia</i> (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>years</i> <i>days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>C.B.S. as with cerebral arteriosclerosis with psychoses fracture of left femur</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <i>The patient was pushed by another patient and fell.</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>10-31-1957</i> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <i>Springfield State Hospital, Sykesville, Anne Arundel Co.</i>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>James T. Marsh</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>JAMES T. MARSH</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11-14-57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>OAK LAWN</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Luck</i>		ADDRESS <i>5305 Hayford</i>	
24a. REC'D BY REGISTRAR <i>C. Harry Wren</i>		24b. REGISTRAR'S SIGNATURE <i>C. Harry Wren</i>	
DATE <i>11-11-57</i>			



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2

NOV 13 1957

RECEIVED

## CERTIFICATE OF DEATH

11759

Reg. Dist. No.

11752

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Taneytown Rural</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Taneytown - Rural</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>✓</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>FRANK - L - SMITH</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>17</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar 13 - 1870</u>
9. AGE (In years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>25</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Miller</u>	
11. BIRTHPLACE (State or foreign country) <u>Illinois</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Edward Smith</u>		14. MOTHER'S MAIDEN NAME <u>Emma Leonard</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-34-3897</u>	
17. INFORMANT <u>Mrs Frank Smith, Taneytown Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIO SCLEROTIC CARDIO VASCULAR DISEASE</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct 29</u> , 19 <u>57</u> , to <u>Nov 17</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov 15</u> , 19 <u>57</u> , and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James J. Marsh</u>		ADDRESS (Street, city or town, state) <u>105 E Main Street</u>	
PHYSICIAN'S NAME (Type) <u>JAMES T MARSH</u>		DATE SIGNED <u>11/18/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 21 - 1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wheatland</u>		22d. LOCATION (City, town, or county) (State) <u>Carroll Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw C Tipton - Taneytown Md</u>		24a. REC'D BY REGISTRAR DATE	
24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>		NOV 25 '57	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2004 2003

BUREAU V. S.

NOV 25 1957

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11704

## CERTIFICATE OF DEATH

Reg. Dist. No.

76

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MID.</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>27 WESTMINSTER</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1 BISHOP ST.</u>		d. STREET ADDRESS <u>11 BISHOP</u>	
3. NAME OF DECEASED (Type or print) <u>LEWIS</u> First <u>ELSWORTH</u> Middle <u>SMITH</u> Last		4. DATE OF DEATH Month <u>11</u> Day <u>19</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 30, 1866</u>
9. AGE (In years last birthday) <u>91</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MID.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>LEVI TIVIS SMITH</u>		14. MOTHER'S MAIDEN NAME <u>LINDA LITTLE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>N/O</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>John W. Smith</u> Address <u>500 Peabody St. N.W.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Left Lung</u> 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Permissive Anemia</u> DUE TO (c) <u>Senility</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>6-8 mo</u> <u>17 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June</u> , 19 <u>50</u> , to <u>Nov. 19</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov 19</u> , 19 <u>57</u> , and that death occurred at <u>10:55 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. Spencer</u>		DATE SIGNED <u>11/24/57</u>	
PHYSICIAN'S NAME (Type) <u>W. Spencer</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11-23-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MEADOW BRANCH CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>WESTMINSTER, MID.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>David A. Bankard</u>		24a. REC'D BY REGISTRAR <u>11-23-57</u>	
ADDRESS <u>Westminster Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Harriet Mulla</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of Deceased: *John Doe*  
 2. Sex: *Male*  
 3. Age: *45*  
 4. Date of Birth: *1912*  
 5. Place of Birth: *John Doe*  
 6. Date of Death: *1957*  
 7. Place of Death: *John Doe*  
 8. Cause of Death: *John Doe*  
 9. Signature of Physician: *John Doe*  
 10. Signature of Registrar: *John Doe*

BUREAU V. 1

NOV 26 1957

RECEIVED



## 11705 CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>CARROLL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WESTMINSTER</b>		c. LENGTH OF STAY IN 1b <b>6 1/2 YRS.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>236 E. GREEN</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>SPINICCHIA</b> Last <b>SPINICCHIA</b>		4. DATE OF DEATH Month <b>11</b> Day <b>16</b> Year <b>1957</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-18-1896</b>
9. AGE (In years last birthday) yrs. <b>61</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SHOE MAKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SICILY, ITALY</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>PHILADELPHIA SPINICCHIA</b>		14. MOTHER'S MAIDEN NAME <b>CAROLINE VIOLETTI</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>218-32-3403</b>	
17. INFORMANT Address <b>236 E. Green St. Westminister, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Lung with</b> <b>163X</b> DUE TO <b>generalized metastases</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>(Operation at Mt. Wilson)</b> (c) <b>(Operation at Mt. Wilson)</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>(Heavy cigarette smoker?)</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 15, 1956</b> , to <b>Nov. 16, 1957</b> , that I last saw the deceased alive on <b>Nov. 13, 1957</b> , and that death occurred at <b>5 A. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>C. L. Billingslea</b> M.D.		ADDRESS (Street, city or town, state) <b>Westminister, Md. 21-16-57</b> DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>C. L. Billingslea</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>11-19-57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>MEMORIAL GARDENS</b>	22d. LOCATION (City, town, or county) (State) <b>FINN'SBURG MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>David C. Bankard</b> ADDRESS <b>Westminister, Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 20 1957</b>	24b. REGISTRAR'S SIGNATURE <b>Harriet Miller</b>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban poppers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. 2

NOV 20 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

11762

Reg. Dist. No. 82

1. PLACE OF DEATH o. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Woodbine</b>		c. LENGTH OF STAY IN 1b <b>6 weeks</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Weitzel Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>FRANKLIN</b> Middle <b>I</b> Last <b>STEPHAN</b>		4. DATE OF DEATH Month <b>Nov</b> Day <b>19</b> Year <b>1957</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 1, 1871</b>
9. AGE (In years last birthday) <b>86</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>	
11. BIRTHPLACE (State or foreign country) <b>Carroll County, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Jacob Stephan</b>		14. MOTHER'S MAIDEN NAME <b>Maria Snyder</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>MISS IDA J. STEPHAN R. 3 WESTMINSTER, MD.</b>	
17. INFORMANT <b>Miss Ida J. Stephan R. 3 Westminister, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac failure, bronchial pneumonia,</b> <b>180X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Anemia, renal insufficiency.</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>OCT 1957</b> <b>TO</b> <b>NOV 1957</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>OCT 1957</b> to <b>19 NOV 1957</b> , that I last saw the deceased alive on <b>19 NOV 1957</b> , and that death occurred at <b>7:11 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Howard E. Hall</b>		DATE SIGNED <b>19 NOV 57</b>	
PHYSICIAN'S NAME (Type) <b>HOWARD E. HALL</b>		ADDRESS (Street, city or town, state) <b>SYKEVILLE, MD.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-22-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Leister's</b>		22d. LOCATION (City, town, or county) (State) <b>Near Westminister, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John R. Byers</b>		ADDRESS <b>Westminister, Maryland</b>	
24. RECEIVED BY REGISTRAR <b>NOV 22 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Edna Hewitt</b>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED [REDACTED]		2. SEX [REDACTED]	
3. AGE [REDACTED]		4. RACE [REDACTED]	
5. DATE OF BIRTH [REDACTED]		6. PLACE OF BIRTH [REDACTED]	
7. DATE OF DEATH [REDACTED]		8. PLACE OF DEATH [REDACTED]	
9. CAUSE OF DEATH [REDACTED]		10. MANNER OF DEATH [REDACTED]	
11. SIGNATURE OF PHYSICIAN [REDACTED]		12. SIGNATURE OF REGISTRAR [REDACTED]	
13. SIGNATURE OF WITNESS [REDACTED]		14. SIGNATURE OF WITNESS [REDACTED]	
15. SIGNATURE OF WITNESS [REDACTED]		16. SIGNATURE OF WITNESS [REDACTED]	
17. SIGNATURE OF WITNESS [REDACTED]		18. SIGNATURE OF WITNESS [REDACTED]	
19. SIGNATURE OF WITNESS [REDACTED]		20. SIGNATURE OF WITNESS [REDACTED]	
21. SIGNATURE OF WITNESS [REDACTED]		22. SIGNATURE OF WITNESS [REDACTED]	
23. SIGNATURE OF WITNESS [REDACTED]		24. SIGNATURE OF WITNESS [REDACTED]	
25. SIGNATURE OF WITNESS [REDACTED]		26. SIGNATURE OF WITNESS [REDACTED]	
27. SIGNATURE OF WITNESS [REDACTED]		28. SIGNATURE OF WITNESS [REDACTED]	
29. SIGNATURE OF WITNESS [REDACTED]		30. SIGNATURE OF WITNESS [REDACTED]	
31. SIGNATURE OF WITNESS [REDACTED]		32. SIGNATURE OF WITNESS [REDACTED]	
33. SIGNATURE OF WITNESS [REDACTED]		34. SIGNATURE OF WITNESS [REDACTED]	
35. SIGNATURE OF WITNESS [REDACTED]		36. SIGNATURE OF WITNESS [REDACTED]	
37. SIGNATURE OF WITNESS [REDACTED]		38. SIGNATURE OF WITNESS [REDACTED]	
39. SIGNATURE OF WITNESS [REDACTED]		40. SIGNATURE OF WITNESS [REDACTED]	
41. SIGNATURE OF WITNESS [REDACTED]		42. SIGNATURE OF WITNESS [REDACTED]	
43. SIGNATURE OF WITNESS [REDACTED]		44. SIGNATURE OF WITNESS [REDACTED]	
45. SIGNATURE OF WITNESS [REDACTED]		46. SIGNATURE OF WITNESS [REDACTED]	
47. SIGNATURE OF WITNESS [REDACTED]		48. SIGNATURE OF WITNESS [REDACTED]	
49. SIGNATURE OF WITNESS [REDACTED]		50. SIGNATURE OF WITNESS [REDACTED]	
51. SIGNATURE OF WITNESS [REDACTED]		52. SIGNATURE OF WITNESS [REDACTED]	
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55. SIGNATURE OF WITNESS [REDACTED]		56. SIGNATURE OF WITNESS [REDACTED]	
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59. SIGNATURE OF WITNESS [REDACTED]		60. SIGNATURE OF WITNESS [REDACTED]	
61. SIGNATURE OF WITNESS [REDACTED]		62. SIGNATURE OF WITNESS [REDACTED]	
63. SIGNATURE OF WITNESS [REDACTED]		64. SIGNATURE OF WITNESS [REDACTED]	
65. SIGNATURE OF WITNESS [REDACTED]		66. SIGNATURE OF WITNESS [REDACTED]	
67. SIGNATURE OF WITNESS [REDACTED]		68. SIGNATURE OF WITNESS [REDACTED]	
69. SIGNATURE OF WITNESS [REDACTED]		70. SIGNATURE OF WITNESS [REDACTED]	
71. SIGNATURE OF WITNESS [REDACTED]		72. SIGNATURE OF WITNESS [REDACTED]	
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89. SIGNATURE OF WITNESS [REDACTED]		90. SIGNATURE OF WITNESS [REDACTED]	
91. SIGNATURE OF WITNESS [REDACTED]		92. SIGNATURE OF WITNESS [REDACTED]	
93. SIGNATURE OF WITNESS [REDACTED]		94. SIGNATURE OF WITNESS [REDACTED]	
95. SIGNATURE OF WITNESS [REDACTED]		96. SIGNATURE OF WITNESS [REDACTED]	
97. SIGNATURE OF WITNESS [REDACTED]		98. SIGNATURE OF WITNESS [REDACTED]	
99. SIGNATURE OF WITNESS [REDACTED]		100. SIGNATURE OF WITNESS [REDACTED]	

BUREAU V. S.

NOV 22 1957

RECEIVED

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CERTIFICATE OF DEATH

11763

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville, Maryland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City</b> 3V014	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>924 N. Calvert St.</b>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>ELLEN</b> Last <b>STEVENS</b>		4. DATE OF DEATH Month <b>11</b> Day <b>13</b> Year <b>19 57</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-6-05</b>
9. AGE (In years last birthday) <b>51 yrs.</b>		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>unk</b>	
11. BIRTHPLACE (State or foreign country) <b>Ireland</b>		12. CITIZEN OF WHAT COUNTRY? <b>Unk.</b>	
13. FATHER'S NAME <b>Cornelius O'Shea</b>		14. MOTHER'S MAIDEN NAME <b>Julia Lynch</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unk</b>		16. SOCIAL SECURITY NO. <b>unk</b>	
17. INFORMANT <b>Hospital Records -- Sykesville, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic cardio-vascular condition</b> DUE TO (c) <b>Hypertension</b> INTERVAL BETWEEN ONSET AND DEATH <b>3 hr.</b> <b>10 yrs</b> <b>?</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5-21-</b> , 19 <b>54</b> , to <b>11-13-</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>11-13-</b> , 19 <b>57</b> , and that death occurred at <b>9:15p.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Springfield State Hospital</b> <b>11-13-57</b>			
ACTUAL SIGNATURE <b>H. Mastin</b> M.D.		PHYSICIAN'S NAME (Type) <b>Morrell N. Mastin, M.D.</b> <b>Sykesville, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<b>Burial</b>	<b>11-18-57</b>	<b>New Cathedral</b>	<b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Robert H. Haight</b>		24a. REC'D BY REGISTRAR DATE <b>11-18-57</b>	
ADDRESS <b>Sykesville, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>C. Harry Allen</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



**BUREAU V. S.**

NOV 19 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>15yrs. 5mos. 24days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westminster 27</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>133 E. Main St.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>H.</b> Last <b>SWARTZBAUGH</b>				4. DATE OF DEATH Month <b>November</b> Day <b>1,</b> Year <b>19 57</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 3, 1884</b>		9. AGE (In years last birthday) <b>73</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James G. Swartzbaugh</b>				14. MOTHER'S MAIDEN NAME <b>Margaret J. Arnold</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT Address <b>Springfield Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> <b>331x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Generalized arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic heart disease.-Chronic alcoholism without psychosis.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b> <b>Years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>19</b> Month, Day, Year a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 1, 19 50</b> , to <b>October 31, 19 57</b> , that I last saw the deceased alive on <b>October 31, 19 57</b> , and that death occurred at <b>1:05A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>11/1/57</b>							
ACTUAL SIGNATURE <b>Walther H. Sonnenfeldt</b> M.D.				DATE SIGNED <b>11/1/57</b>			
PHYSICIAN'S NAME (Type) <b>Walther H. Sonnenfeldt, M.D.</b>				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-3-1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Dur Park Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Westminster Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>David G. Barbour</b>				ADDRESS <b>Westminster, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>11-4-57</b>	
						24b. REGISTRAR'S SIGNATURE <b>E. Harry Steers</b>	

BUREAU V. 3

NOV 6 1957

RECEIVED

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

Reg. No. 100

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

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CAUSE OF DEATH

AGE

SEX

RACE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11756

CERTIFICATE OF DEATH

11765

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Henryton</b>				c. LENGTH OF STAY IN 1b <b>602 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Henryton State Hospital</b>				d. STREET ADDRESS <b>223, Fremont Avenue</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Charles Henry Thomas</b>				4. DATE OF DEATH Month Day Year <b>November 29 1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-23-1908</b>	
9. AGE (In years last birthday) <b>49</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Bellevue, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
13. FATHER'S NAME <b>Charles H. Thomas</b>				14. MOTHER'S MAIDEN NAME <b>Mamie Davis</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-09-6326</b>		17. INFORMANT Address <b>Charles Henry Thomas - Patient</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Insufficiency</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pulmonary Cirrhosis</b> DUE TO (c) <b>Far advanced pulmonary tuberculosis</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>April 6, 1956</b> , to <b>Nov. 29, 1957</b> , that I last saw the deceased alive on <b>November 29, 1957</b> , and that death occurred at <b>4:15 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Henryton, Maryland</b> DATE SIGNED <b>11-29-57</b>							
ACTUAL SIGNATURE <b>Dr. E. M. Maculans</b> M.D.							
PHYSICIAN'S NAME (Type) <b>Dr. Edgars M. Maculans, Supt.</b>				Henryton State Hospital, Henryton, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-1-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Easton</b>		22d. LOCATION (City, town, or county) (State) <b>Talbot Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James B. Wasieleski</b>				ADDRESS		24a. REC'D BY REGISTRAR DATE <b>12-1-57</b>	
						24b. REGISTRAR'S SIGNATURE <b>Albert R. Smith</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE OF DEATH		CITY	
BALTIMORE		BALTIMORE	
COUNTY		BALTIMORE	
DECEASED		JAMES H. THOMAS	
DATE OF DEATH		NOVEMBER 21, 1957	
AGE		62	
SEX		MALE	
RACE		WHITE	
MARRIED		YES	
OCCUPATION		FARMER	
EDUCATION		HIGH SCHOOL	
BIRTH DATE		JANUARY 1, 1895	
BIRTH PLACE		BALTIMORE, MARYLAND	
CAUSE OF DEATH		HEART DISEASE	
MANNER OF DEATH		NATURAL	
SIGNATURE OF PHYSICIAN		JAMES H. THOMAS	
SIGNATURE OF WITNESSES		JAMES H. THOMAS	
SIGNATURE OF DECEASED		JAMES H. THOMAS	

RECEIVED  
DEC 4 1957  
BUREAU V. S.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11766

11757

## CERTIFICATE OF DEATH

Reg. Dist. No.

74

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City 311</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>6 months</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
3. NAME OF DECEASED (Type or print) First <b>Concetta</b> Middle <b>Cutrona</b> Last <b>Timpano</b>		4. DATE OF DEATH Month <b>11</b> - Day <b>8</b> - Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-6-84</b>
9. AGE (In years last birthday) <b>72</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Italy</b>		12. CITIZEN OF WHAT COUNTRY? <b>Italy</b>	
13. FATHER'S NAME <b>Jaiacomo Cutrona</b>		14. MOTHER'S MAIDEN NAME <b>Angela Roschella</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>213-10-2887</b>	
17. INFORMANT <b>Hospital records.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>491X</b> not DUE TO <b>Diabetes Mellitus</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>260X</b> (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. associated with cerebral arteriosclerosis, with psychotic reaction</b> <b>Decubitus ulcers.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5-8-1957</b> to <b>11-8-1957</b> , that I last saw the deceased alive on <b>11-8-57</b> , and that death occurred at <b>6.30P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Agustin del Campo</b> M.D.		ADDRESS (Street, city or town, state) <b>Springfield State Hospital.</b>	
PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		DATE SIGNED <b>11-8-57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>11-12-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>BDABROWSKI 2818 E. BALTIMORE ST.</b>		24. REGISTERED BY REGISTRAR <b>NOV 18 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>C. Henry Hersh</b>			

CERTIFICATE OF DEATH

1957

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is oriented horizontally but contains vertical text labels for various fields.

BUREAU V. S.

NOV 18 1957

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

11767

Reg. Dist. No.

11758

1. PLACE OF DEATH a. COUNTY <u>Garroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u> 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Tuers</u> Last <u>Tuers</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>7</u> Year <u>19 57</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 29, 1887</u>
9. AGE (In years lost birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u>-</u> Days <u>-</u>	IF UNDER 24 HRS. Hours <u>-</u> Min. <u>-</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>marine Employee Baltimore, Md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Arthur Tuers</u>		14. MOTHER'S MAIDEN NAME <u>Emma Butler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Records of Springfield State Hosp. Sykesville Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Paranoid condition, Pulmonary tuberculosis, Diabetes</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 27</u> , 19 <u>49</u> , to <u>Nov. 7</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Nov. 7</u> , 19 <u>57</u> , and that death occurred at <u>1:30 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Springfield State Hosp. Sykesville Maryland</u> DATE SIGNED			
ACTUAL SIGNATURE <u>Ilse Kamm</u>		M.D. <u>Springfield State Hosp. Sykesville Maryland</u>	
PHYSICIAN'S NAME (Type) <u>Ilse Kamm</u>			
22a. BURIAL CREMATION: REMOVAL (Specify) <u>SPECIAL</u>	22b. DATE THEREOF <u>11-10-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Annes</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Foster</u>		ADDRESS <u>Annapolis Md.</u>	
24a. REC'D. BY REGISTRAR <u>U. S. A.</u>		24b. REGISTRAR'S SIGNATURE <u>C. H. Green</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 and 4, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, date of death, cause of death, and place of death. The form is filled out with handwritten text.

NAME: *John Doe*  
AGE: *45*  
SEX: *Male*  
RACE: *White*  
DATE OF DEATH: *Nov 15 1953*  
PLACE OF DEATH: *Home*  
CAUSE OF DEATH: *Heart Disease*

BUREAU V. S.

NOV 15 1953

RECEIVED

## CERTIFICATE OF DEATH

11768

Reg. Dist. No.

11759

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>2yr, 5mo, 5dy</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>313 East 31st Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Bessie</b> Middle <b>Grace</b> Last <b>Turnbaugh</b>		4. DATE OF DEATH Month <b>November</b> Day <b>19</b> Year <b>19 57</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 27, 1881</b>
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Alteration worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hutzler's Dept. Store</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Turnbaugh</b>		14. MOTHER'S MAIDEN NAME <b>Cecelia Knight</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-10-2096A</b>	
17. INFORMANT <b>Springfield Hospital records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronconeumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>422.1</b> (b) <b>arteriosclerotic Cardio-vascular disease</b> DUE TO (c) <b>various disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CBS assoc. with disturbance of metabolism, growth or nutrition, with senile brain disease, with psychotic reaction</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June 11, 19 55</b> , to <b>November 19, 19 57</b> , that I last saw the deceased alive on <b>November 19, 19 57</b> , and that death occurred at <b>8:25 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Elizabeth Knopp</b>		ADDRESS (Street, city or town, state) DATE SIGNED <b>Springfield State Hosp, Sykesville</b>	
PHYSICIAN'S NAME (Type) <b>Elizabeth Knopp</b>		M.D. <b>Springfield State Hosp, Sykesville</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>11/22/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Jessops Methodist</b>	22d. LOCATION (City, town, or county) (State) <b>Sparks, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>L. Scott Brooks</b>		ADDRESS <b>622 York Rd., Towson 4, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>NOV 25 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Harry Perry</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
JAMES EARL RAY		MAY 14 1968	
AGE		SEX	
35		Male	
RACE		ETHNIC ORIGIN	
White		American	
BIRTH DATE		BIRTH PLACE	
JAN 12 1933		MEMPHIS, TENN.	
MARRIAGE DATE		MARRIAGE PLACE	
OCCUPATION		EDUCATION	
Attorney		High School	
PREVIOUS ILLNESS		CAUSE OF DEATH	
None		Gunshot wound	
MANNER OF DEATH		PLACE OF DEATH	
Suicide		Prison	
CERTIFICATE OF DEATH		SIGNATURE OF DECEASED	
JAMES EARL RAY		JAMES EARL RAY	
DATE OF DEATH		DATE OF DEATH	
MAY 14 1968		MAY 14 1968	
PLACE OF DEATH		PLACE OF DEATH	
Prison		Prison	
CAUSE OF DEATH		CAUSE OF DEATH	
Gunshot wound		Gunshot wound	
MANNER OF DEATH		MANNER OF DEATH	
Suicide		Suicide	

BUREAU V. S.

NOV 25 1967

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No.

74

11760

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>12yrs. 3mos. 6days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>-</b>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Martine</b> Last <b>Robinette</b> <b>TWIGG</b>				4. DATE OF DEATH Month <b>November</b> Day <b>7</b> Year <b>1957</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>May 18, 1909</b>	
9. AGE (In years last birthday) <b>48</b> yrs.		IF UNDER 1 YEAR Months <b>48</b> Days <b>0</b> Hours <b>0</b> Min.		IF UNDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Fred L. Robinette</b>				14. MOTHER'S MAIDEN NAME <b>Blanche Stallings</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Springfield Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accident, type to be de-</b> <b>4343</b> DUE TO 2. <b>Interstitial pneumonitis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO <b>terminated by further studies.</b> INTERVAL BETWEEN ONSET AND DEATH <b>Days</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Post-infectious psychosis, Parkinsonism.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>19</b> o. m. <b>0</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July 1, 1950</b> , to <b>November 7, 1957</b> , that I last saw the deceased alive on <b>November 7, 1957</b> , and that death occurred at <b>9:30A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Walther H. Sonnenfeldt</b>				ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>11/7/57</b>			
PHYSICIAN'S NAME (Type) <b>Walther H. Sonnenfeldt, M.D.</b>				<b>Sykesville, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 9, 1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>STALLINGS Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>OLD TOWN M.D.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Thos J HAFER-CAMBERLAND</b>				ADDRESS <b>DATE 11/7/57</b>		24a. REC'D BY REGISTRAR <b>C. Harry Allen</b>	
				24b. REGISTRAR'S SIGNATURE			

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

BUREAU V. S.

NOV 13 1957

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NOV 11 1957

CARROLL CO. HEALTH DEPT.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3, could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 11761 CERTIFICATE OF DEATH

11770

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Taneytown</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X/ Rural Taneytown</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Helen</u> Middle <u>Genevieve</u> Last <u>Unger</u>		4. DATE OF DEATH Month <u>November</u> Day <u>7</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 9, 1907</u>
9. AGE (In years last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Herbert Eyler</u>		14. MOTHER'S MAIDEN NAME <u>Lottie Heffner</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Mr. Charles R. Unger, Taneytown, Md. R # 1</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma</u> <u>175x</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> lying cause last. (b) <u>Carcinoma of the fallopian tubes</u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u> <u>6 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August</u> , 19 <u>56</u> , to <u>November 7</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>November 7</u> , 19 <u>57</u> , and that death occurred at <u>  </u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Leah Maitland</u> M.D. <u>50 Maple Ave, Littlestown Pa 11/8/57</u> PHYSICIAN'S NAME (Type) <u>Leah Abel Maitland</u> <u>50 Maple Ave, Littlestown Pa</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/10/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lutheran Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Taneytown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Merwyn C. Fuss</u>		ADDRESS <u>Merwyn C. Fuss, Taneytown,</u>	
24a. REC'D BY REGISTRAR <u>NOV 12 '57</u>		24b. REGISTRAR'S SIGNATURE <u>Research</u>	

BUREAU V. S.

NOV 12 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11762

## CERTIFICATE OF DEATH

11771

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Banall</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Banall</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>		c. LENGTH OF STAY IN 1b <u>2 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>✓</u>		d. STREET ADDRESS <u>1</u>	
3. NAME OF DECEASED (Type or print) <u>LOUISE</u> First <u>WARD</u> Middle Last		4. DATE OF DEATH <u>Nov</u> Month <u>17</u> Day <u>1957</u> Year	
5. SEX <u>FA</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 28-1886</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>cook</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Sanders Young</u>		14. MOTHER'S MAIDEN NAME <u>Jane Gough</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Chas Ward - Manchester Md</u> Address <u>  </u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Anteriosclerotic Heart Disease</u> DUE TO <u>  </u> (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>5 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>7/20/55</u> , 19 <u>55</u> , to <u>11/17</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>11/15</u> , 19 <u>57</u> , and that death occurred at <u>6:30 p</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W H Foard</u>		DATE SIGNED <u>11/18/57</u>	
PHYSICIAN'S NAME (Type) <u>W H Foard</u>		ADDRESS (Street, city or town, state) <u>Manchester Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov 20/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>	22d. LOCATION (City, town, or county) (State) <u>Banall Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw Clifton - Hampstead Md</u>		24a. REC'D BY REGISTRAR <u>  </u> DATE <u>11-18-57</u>	24b. REGISTRAR'S SIGNATURE <u>Caroline K. Skinner</u> <u>Per. Jeanette Skinner</u>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11763

## CERTIFICATE OF DEATH

11772

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>1 mo. 17 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
f. STREET ADDRESS <b>3520 N. Hilton Rd.</b>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Bessie</b> Middle <b>May</b> Last <b>WARNER</b>				4. DATE OF DEATH Month <b>November</b> Day <b>24</b> , Year <b>19 57</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 5, 1881</b>	
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>Yak</b>		17. INFORMANT <b>Springfield Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Malnutrition</b> DUE TO (c) <b>Senile psychosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senile psychosis</b> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from <b>October 7, 1957</b> , to <b>November 24, 1957</b> , that I last saw the deceased alive on <b>November 24, 1957</b> , and that death occurred at <b>11:10 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield Hospital</b> DATE SIGNED <b>11/25/57</b> ACTUAL SIGNATURE <b>Walther H. Sonnenfeldt</b> M.D. <b>Springfield Hospital</b> PHYSICIAN'S NAME (Type) <b>Walther H. Sonnenfeldt, M.D.</b> <b>Sykesville, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>1957-9-1957</b>		<b>Horrame Park</b>		<b>Baltimore Co. Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Horace F. Surgee</b>				24a. REC'D BY REGISTRAR <b>11/25/57</b>		24b. REGISTRAR'S SIGNATURE <b>C. H. H. H.</b>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

11773

11764

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural--Finksburg</b>		c. LENGTH OF STAY IN 1b <b>50 yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ADA</b> Middle <b>ALBERTA</b> Last <b>WILLIAMS</b>		4. DATE OF DEATH Month <b>NOV.</b> Day <b>14,</b> Year <b>1957</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 10, 1880</b>
9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months <b>77</b> Days <b>77</b> Hours <b>77</b> Min. <b>77</b>	IF UNDER 24 HRS. Months <b>77</b> Days <b>77</b> Hours <b>77</b> Min. <b>77</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Joseph T. Parrish</b>		14. MOTHER'S MAIDEN NAME <b>Mary Alice Gorsuch</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>Mrs. Fred Ludwig, Finksburg, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>cardio Vascular Disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>arterio-sclerosis + senility</b> DUE TO (c) <b>5 years</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <b>11</b> p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov. 13</b> , 19 <b>57</b> , to <b>Nov. 15</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Nov. 13</b> , 19 <b>57</b> , and that death occurred at <b>3 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Westminster, Md. 11-15-57</b>			
ACTUAL SIGNATURE <b>G. L. Billingslea</b> M.D.		PHYSICIAN'S NAME (Type) <b>G. L. Billingslea</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>11-17-1957</b>	
22c. NAME OF CEMETERY <b>Mt. Pleasant</b>		22d. LOCATION (City, town, or county) (State) <b>Gamber, Carroll Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C.M. Waltz, Winfield, Md.</b>		24a. REC'D BY REGISTRAR <b>Nov 18 1957</b>	
24b. REGISTRAR'S SIGNATURE <b>Harriet Mulvey</b>			



MASSACHUSETTS STATE DEPARTMENT OF HEALTH—BELLINGHUE 18

251 31 NOV

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G223 12-23-57 et

11765

## CERTIFICATE OF DEATH

11774

Reg. Dist. No. 74

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN TB <b>2 mos. 20 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>600 Green St.</b>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Henry</b> Last <b>WORKMEISTER</b>				4. DATE OF DEATH Month <b>November</b> Day <b>25</b> Year <b>1957</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 2, 1883</b>	
9. AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Claim agent</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Louis Workmeister</b>				14. MOTHER'S MAIDEN NAME <b>Amelia Workmeister</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>705-0349823</b>		17. INFORMANT <b>Springfield Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>491X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH <b>Days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fracture, right femur. -C.B.S. assoc. with cerebral arteriosclerosis, with psychotic reaction.</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>904.9</b>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>Unknown</b> 19 <b>57</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hospital</b>	
20f. (City or town) <b>Sykesville</b>				(County) <b>Carroll</b>		(State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>September 5, 1957</b> , to <b>November 25, 1957</b> , that I last saw the deceased alive on <b>November 25, 1957</b> , and that death occurred at <b>10:15 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Walther H. Sonnenfeldt</b>				ADDRESS (Street, city or town, state) <b>Springfield Hospital</b>		DATE SIGNED <b>11/25/57</b>	
PHYSICIAN'S NAME (Type) <b>Walther H. Sonnenfeldt, M.D.</b>				<b>Sykesville, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11-27-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>HillCrest Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b>				ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR <b>11-26-57</b>	
				24b. REGISTRAR'S SIGNATURE <b>P. Harry Wren</b>			

CERTIFICATE OF DEATH

1957

Form with multiple fields for death certificate information, including name, date, and cause of death. The text is mostly illegible due to the quality of the scan.

BUREAU V. S.

NOV 27 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11775

11766

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>11 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 24</b> <b>3V01-4</b>	
f. STREET ADDRESS <b>3509 Esther Place</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Ada</b> Middle <b>Haworth</b> Last <b>YATES</b>		4. DATE OF DEATH Month <b>November</b> Day <b>2</b> Year <b>1957</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 12, 1874</b>
9. AGE (In years last birthday) <b>83 yrs.</b>		IF UNDER 1 YEAR Months <b>83</b> Days <b>83</b> Hours <b>83</b> Min. <b>83</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>England</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas Haworth</b>		14. MOTHER'S MAIDEN NAME <b>Mary Haworth</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypochromic anemia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>291X</b> DUE TO (c) <b>1</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. due to arteriosclerotic brain disease.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <b>19</b> Day <b>19</b> Year <b>19</b> Hour <b>a. m.</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October 21, 1957</b> to <b>November 2, 1957</b> , that I last saw the deceased alive on <b>November 2, 1957</b> , and that death occurred at <b>11:00A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>11/2/57</b> ACTUAL SIGNATURE <b>Edmund Lusthaus</b> PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus, M.D.</b> <b>Sykesville, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial Nov. 5/57</b>		22b. DATE THEREOF <b>Nov. 5/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Philip Herwigson Orleans</b>		24. REGISTRAR'S SIGNATURE <b>C. Harry Kepp</b>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES H. HARRIS		Male		35		1898	
PLACE OF BIRTH		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
Baltimore, Md.		Carpenter		Heart Disease		Natural	
DATE OF DEATH		PLACE OF DEATH		HOURS OF DEATH		TEMPERATURE AT DEATH	
Nov 5, 1957		Baltimore, Md.		10:00 AM		98.6	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		DATE OF REGISTRATION		PLACE OF REGISTRATION	
J. H. Harris		J. H. Harris		Nov 5, 1957		Baltimore, Md.	

BUREAU V. S.

NOV 5 1957

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11767

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 74

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>10 hrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield Hospital Records</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Herbert</b> Middle <b>Bremer</b> Last <b>ZISSETT</b>		4. DATE OF DEATH Month <b>November</b> Day <b>29</b> Year <b>1957</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 15, 1902</b>
9. AGE (in years last birthday) <b>55</b> yrs.		10. IF UNDER 1 YEAR Months <b>5</b> Days <b>14</b> Hours <b>4</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Edward Zissett</b>		14. MOTHER'S MAIDEN NAME <b>Hermine Bremer</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-05-3465</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute hepatitis</b> <b>580x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Personality Pattern Disturbance, Schizoid personality, alcoholism.</b> <b>322.2</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James T. Marsh</b> EXAMINER'S NAME (Type) <b>James T. Marsh, M.D.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		22b. DATE THEREOF <b>12/5/57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Crematory</b>		22d. LOCATION (City, town, or county) _____ (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tickener + Sons Inc.</b>		24a. REC'D BY REGISTRAR <b>C. Harry Heery</b>	
ADDRESS <b>Baltimore, Md.</b>		24b. REGISTRAR'S SIGNATURE	

1957

NOT STATE  
MAY 1957

Name of Deceased		Sex		Age	
Date of Death		Time of Death		Place of Death	
Cause of Death		Manner of Death		Occupation	
Medical History		Physical Examination		Mental Examination	
Autopsy		Toxicology		Microbiology	
X-ray		Laboratory		Other	
Signature of Examiner		Signature of Coroner		Signature of Physician	
Date of Report		Time of Report		Place of Report	

BUREAU V. S.

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